STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE S	ETED	
		155166	B. WIN			03/15/2	011
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	•	606 WA	ADDRESS, CITY, STATE, ZIP CODE ALL ST RAISO, IN46383		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
F0000	This visit was for State Licensure Sincluded the Investination Involved Inv	r a Recertification and Survey. This visit estigation of Complaint 087434 - Substantiated. Sciencies related to the ted at F225, F226, and arch 7, 8, 9, 10, 11, and 000083 : 155166 100289670 RN,TC N RN RN RN	F00		The creation and submission of the Plan of Correction does not constitute an admission by this provider of any conclusion set for in the statement of deficiencies, or any violation of regulation. This provider respectfully request that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a post sur revisit on or after April 15, 2011.	rth r of ts pe	
LABORATOR	Y DIRECTOR'S OR PROV	TDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: HNBL11 Facility ID: 000083

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		155166	A. BUILDING B. WING		03/15/2011	
NAME OF F	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
		EHABILITATION CENTER	VALPA	RAISO, IN46383		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E COMPLETION	
IAG	Sample:	24	mo		DAIL	
	Sample: Supplemental sampl These deficiencies a accordance with 410	24 le: 20 also reflect state findings in				

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:		DDIC		COMPLETED	
		155166	A. BUII B. WIN			03/15/20	011
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			606 WA			
VALPARA	AISO CARE AND R	EHABILITATION CENTER		l	RAISO, IN46383		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0176	Based on observa	ation, record review, and	F01	76	F176 RESIDENT SELF-ADMINIST	ΓER	04/15/2011
SS=D	interview, the fac	cility failed to ensure a			DRUGS IF NEEDED SAFE		
	resident had been	n assessed and			An individual resident may self-administer drug if the		
	determined to be	safe to administer her			interdisciplinary team has determ	ined	
		related to, medications			that this practice is safe.	linea	
					time practice to build.		
	left at the bedside and an order to keep				What corrective action(s) will be	e	
		bedside, for 1 of 24			accomplished for those residents		
		ed for medications in a			found to have been affected by t	he	
	sample of 24. (Re	esident #82)			deficient practice		
	Findings include:				There is no corrective actifor resident #82 since the alleged.		
	During the initial to LPN #6, Resident #8 her rocker. The tabl hand held inhalers la first inhaler was Spi Advair 250/50. Res already administered would pick them up Resident #82's re 03/08/11 at 3:25 diagnoses includ to, glaucoma and pulmonary disease. The Resident's P. Orders, dated 03/2 Spiriva Handihal medication), inhall Diskus (breathing puff twice daily,	ur on 3/7/11 at 9:45 a.m., with 82 was observed sitting up in le beside the resident had two aying on top of the table. The riva and the second was sident #82 indicated she had d the inhalers and respiratory later. ecord was reviewed on p.m. The resident's ed, but were not limited d chronic obstructive se. hysician's Recapitulation /11, indicated an order for ler (breathing ale one puff daily, Advair g medication), inhale one and Xalatan (eye drops)			for resident #82 since the alleged deficiency was in the past. How will you identify other residents having the potential to affected by the same deficient practice and what corrective action will be taken All residents have the potential to be affected by the alledeficient practice. Licensed nurses and respiratory staff will be educated the Director of Nursing Services/designee on the proper procedures required prior to self-administration of medication 4/15/11. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur	be be eged by	
	0.005%, instill of	ne drop in both eyes at			Customer Care Representative	es,	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріш	A. BUILDING		COMPLETED	
		155166	B. WING			03/15/2011	I
			D. WITK		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			606 WA			
	AISO CARE AND R	EHABILITATION CENTER			RAISO, IN46383		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE CO	OMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	bedtime, may ke	ep at bedside.			nurses and Unit		
					· Managers will assess th	I	
	The Resident's re	ecord lacked			environment for medications to	nat	
		o indicate the resident had			may have been left at the bedside.		
		r safe self-administration			All residents who		
	of medication.	i sare sen-administration			self-administer medications w	ıı İ	
	of medication.				have an assessment complete		
					to ensure safety and their		
	There was a lack	of documentation on the			capability of self-medication		
	Resident's Physic	cian's Recapitulation			administration.		
	orders, dated 03/	11, to indicate the			· Nursing Round sheets v	vill	
	resident had an order to self-administer				be reviewed daily by the		
the Spiriva and Advair inhalers.				DNS/designee for any discrepancies.			
	During an interview on 03/09/11 at 2:15				Noncompliance with factors	sility	
					policy and procedure may res		
	_				in employee re-education and		
	•	r of Nursing indicated the			disciplinary action up to and		
		nave an assessment to			including termination.		
	self-administer h	er medications.					
					How the corrective action(s)	I	
	3.1-11(a)				will be monitored to ensure t		
	, ,				deficient practice will not rec	ur,	
					i.e., what quality assurance	_	
					program will be put into plac	e	
					A "Self-Administration o	.f	
					Medication" CQI tool will be	'	
					utilized weekly x 4, then month	nly	
					thereafter.	´	
					 Data will be submitted t 	o	
					the CQI Committee for review		
					and follow up.		
					· Action plans will be		
					developed as needed for issue identified to improve complian		
						∪ C .	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	NG		COMPLETED 03/15/2011	
		155166	B. WING			03/15/20	711	
NAME OF P	PROVIDER OR SUPPLIER			606 WA	ADDRESS, CITY, STATE, ZIP CODE			
VALPARA	AISO CARE AND RE	EHABILITATION CENTER			RAISO, IN46383			
(X4) ID		TATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (FACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROLEMENT OF THE PROPERTY OF T		CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE	
F0221	Based on observation, record		F0221		F221 RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS		04/15/2011	
SS=D	review, and interview, the				The resident has the right to be fr			
	facility failed	d to ensure a			from any physical restraints impo for purpose of discipline or	sed		
	•	not physically			convenience, and not required to			
	restrained without the appropriate diagnosis, without any attempts at reduction, and applied per family request, for				treat the resident's medical symptoms.			
					What corrective action(s) will be			
					accomplished for those residents			
					found to have been affected by t	he		
	1 of 1 resident with physical restraints in a sample of 24.				deficient practice			
					There is no corrective active.	on		
					for resident #89 since the alleged			
	(Resident #8	9).			deficiency was in the past.			
	Findings include:				How will you identify other residents having the potential to affected by the same deficient practice and what corrective	be		
	1 During the	e initial tour on			action will be taken			
	•	5 a.m., the West			All residents with restraint	~		
		*			have the potential to be affected be the alleged deficient practice.	ру		
	Unit Manage				All staff will be educated I	ру		
	Resident #89	had a self release			the Director of Nursing			
	belt alarming	g belt which was a			Services/designee on residents right to be	free		
	physical rest	raint.			from the use of physical restra			
	- -				by 4/15/11.			
		9's record was			What measures will be put in	to		
		3/8/11 at 9:23 a.m.			place or what systemic changes you will make to			
	Resident #89	9's diagnoses			ensure that the deficient			
	included, but	t were not limited			practice does not recur			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
		155166	A. BUII B. WIN			03/15/2011	
NAME OF I	PROVIDER OR SUPPLIER	<u>.</u>	<u> </u>		ADDRESS, CITY, STATE, ZIP CODE		
VALPARA	AISO CARE AND R	EHABILITATION CENTER		606 WA	RAISO, IN46383		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) Pr's Disease		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE
	Order Recap 3/11, indicate 8/13/10, for velcro seat be when up in velcase belt observe skin irritation. A care plan, indicated "(I name) uses a belt with ala wheelchair, will be safe restrictive depossibleIn e belt and rehoursInterto review even	9's Physician's pitulation, dated deed orders, dated the self releasing pelt with alarm wheelchair and every two hours to a for any redness or dated 9/3/10, Resident #89's self releasing velcro rm while up in Goals: Resident with the least			restraints were re-assessed by the Interdisciplinary Team to ensure compliance with the Restraint Policy and Procedure Recommendations were followed-up by the Unit Managers. The Interdisciplinary Team Policy and Procedure by 4/15/15/15/15/15/15/15/15/15/15/15/15/15/	e. am int 11, e aint 11, r f ts n is int m tly , to e thly ts	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155166 A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 606 WALL ST VALPARAISO CARE AND REHABILITATION CENTER VALPARAISO, IN46383 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) A "PHYSICAL RESTRAINT ASSESSMENT" dated 8/13/10, indicated the medical A BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 606 WALL ST VALPARAISO, IN46383 (X5) PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG PROVIDERS PLAN OF CORRECTION (COMPLETE CROSS-REFERENCED TO THE APPROPRIATE DATE A REStraint CQI tool is utilized weekly x 4, monthly x 2, and quarterly, thereafter, to monitor compliance with resident restraint assessment, implementation and	
NAME OF PROVIDER OR SUPPLIER VALPARAISO CARE AND REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) A "PHYSICAL RESTRAINT ASSESSMENT" dated 8/13/10, STREET ADDRESS, CITY, STATE, ZIP CODE 606 WALL ST VALPARAISO, IN46383 (X5) PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) A Restraint CQI tool is utilized weekly x 4, monthly x 2, and quarterly, thereafter, to monitor compliance with resident restraint assessment.	
VALPARAISO CARE AND REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A "PHYSICAL RESTRAINT ASSESSMENT" dated 8/13/10, BY ONL ST VALPARAISO, IN46383 (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE A "PHYSICAL RESTRAINT ASSESSMENT" dated 8/13/10, A "PHYSICAL RESTRAINT ASSESSMENT" dated 8/13/10,	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A "PHYSICAL RESTRAINT ASSESSMENT" dated 8/13/10, ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL RESULT TAG) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE A "PHYSICAL RESTRAINT ASSESSMENT" dated 8/13/10, A "PHYSICAL RESTRAINT MONITOR COMPLIANCE WITH TRESIDENT COMPLETE COMPLIANCE WITH TRESIDENT COMPLETE OF THE APPROPRIATE COMPLETE	
PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A "PHYSICAL RESTRAINT ASSESSMENT" dated 8/13/10, PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDERS PLAN OF CORRECTION SHOULD BE COMPLETIC TO THE APPROPRIATE DEFICIENCY) DATE COMPLETIC TO THE APPROPRIATE DEFICIENCY A Restraint CQI tool is utilized weekly x 4, monthly x 2, and quarterly, thereafter, to monitor compliance with resident restraint assessment.	
tag regulatory or LSC IDENTIFYING INFORMATION) devices" A "PHYSICAL RESTRAINT ASSESSMENT" dated 8/13/10, REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) A Restraint CQI tool is utilized weekly x 4, monthly x 2, and quarterly, thereafter, to monitor compliance with resident restraint assessment.	
A "PHYSICAL RESTRAINT ASSESSMENT" dated 8/13/10, A Restraint CQI tool is utilized weekly x 4, monthly x 2, and quarterly, thereafter, to monitor compliance with resident restraint assessment.	
A "PHYSICAL RESTRAINT ASSESSMENT" dated 8/13/10, utilized weekly x 4, monthly x 2, and quarterly, thereafter, to monitor compliance with resident restraint assessment.	
symptoms/diagnosis that lead to the use of the restraint was "repeated falls." The current order for physical restraint was self release velcro belt with alarm when up in wheelchair. The Interdisciplinary Team Progress Notes indicated: 8/4/11 at 11:30 a.m., "IDT (Interdisciplinary Team) met to review unassisted fall witnessed on 8/3/10 at 11:15 a.mRes was in w/c (wheelchair). PAC (chair alarm) sounded CNA responded assisted res into w/c was propelling res down hall in w/c when she stood & fellRes to be ambulated to & from	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
		155166	A. BUI B. WIN	LDING G		03/15/2	
NAME OF I	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE		
VALPAR	AISO CARE AND R	EHABILITATION CENTER		606 WA	LLST RAISO, IN46383		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	` `	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
	meals & who	en noted to be					
	attempting to	o stand from w/c"					
	8/10/10 at 12	2:15 p.m., " SS					
	(Social Serv	ices), DNS					
	(Director of	Nursing Services),					
	UM (unit ma	anager) meet c					
	(with) Res's	(Resident's) dau					
	(daughter) (1	name) & son (son's					
	name). (Resident daughter's						
	name) & (Resident's son's						
	name) expressed concern over						
	the number of	of falls that					
	(Resident #8	39's name) had.					
	They were in	nsistent that they					
	do not want	to see (Resident					
	#89) receive	any broken bones					
	or serious						
	injuriesInt	erventions that					
	have already	been put into					
	place in atte	mpts to prevent					
	further falls	were reviewed c					
	(Son and Da	ughter's names)					
	(Daughter a	nd Son's names)					
	expressed th	eir thankfulness c					
	all the interv	ventions attempted,					

PRINTED: 04/15/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUILDING			(X3) DATE : COMPL 03/15/2	ETED
NAME OF I	PROVIDER OR SUPPLIE	₹	·		DDRESS, CITY, STATE, ZIP CODE		
VALPAR	AISO CARE AND R	EHABILITATION CENTER		606 WA	RAISO, IN46383		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES SCY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.ΤΕ	(X5) COMPLETION DATE
	but verbaliz	ed their desire for a					
	restraintIt was explained that						
	if a restraint	is to be used that it					
	must start w	ith the least					
	restrictive, v	which would be a					
	self release	belt to w/c. It was					
	explained th	at this item would					
	have to be orderedAfter						
	review of possible						
	risks/consequences of use of						
	self release belt (Daughter and						
	Son's names	s) still requested the					
	use of said r	restraint. It was					
	noted that th	ne process of					
	ordering sai	d restraint would be					
	initiated."						
	8/13/10 at 1	p.m., "Self					
		lcro seat belt c					
	_	ed as ordered. No					
	(indicated b	y a o) attempts					
	· ·	ease belt at this					
	time. Belt v	vas released during					
		y restraint review					
	completed e	•					
	assessment						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

HNBL11 Facility ID:

000083

If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					NSTRUCTION	COMPL	
		155166	A. BUI B. WIN	LDING IG		03/15/2	011
NAME OF I	PROVIDER OR SUPPLIER	! }			ADDRESS, CITY, STATE, ZIP CODE		
VAI PAR	AISO CARE AND R	EHABILITATION CENTER		606 WA	ILL ST RAISO, IN46383		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	,		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		le to propel self in					
		difficulty"					
		0:30 a.m., "IDT					
	met to revie	w for 30 day					
	restraint rev	iew. Res has					
	tolerated sel	f release velcro belt					
	c alarm well	no (indicated by					
	a o) falls since initiation.						
	Spoke with res daughter (name)						
	& she is happy c use & has not						
	noted any change in res						
		psychosocial states					
	20 (secondar	- 1					
	(2.2.2.2.2.2.2.2.2.2.2.2.2.2.2.2.2.2.2.	<i>J</i> • • • <i>y</i> • • • • • • • • • • • • • • • • • • •					
	 The "30 Day	y Restraint Review"					
	forms, dated						
	ĺ	2/8/10, 1/5/11,					
	ĺ	3/2/11, all indicated					
	· ·	used a self release					
		with alarm. The					
		or the continued use					
		int were "safety					
	_	20 cognitive loss					
	l , –	es) Alzheimer's,					
	senile deme	ntia"					

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155166	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION	(X3) DATE SURVEY COMPLETED 03/15/2011	
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	606 WA	ADDRESS, CITY, STATE, ZIP CODE NLL ST RAISO, IN46383	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	O BE	(X5) COMPLETION DATE
	sitting in her the velcro be her lap at the 3/7/11 at 12: 3/8/11 at 8:2 p.m. 3/9/11 at 9:2 During an in at 11:25 a.m Manager ind was reviewe She indicate been falling the restraint there had no to reduce the needed to at resident's resident's resident's resident's resident's resident.	9 a.m. Atterview on 3/8/11 In the West Unit dicated, the restraint dicated, the restraint dicated the resident had prior to applying. She indicated the been any attempts a restraint and they tempt to reduce the straint. The dicated the straint dicated the resident and they tempt to reduce the straint.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155166			(X2) MULTIPLE C A. BUILDING	CONSTRUCTION	COMPI	(X3) DATE SURVEY COMPLETED 03/15/2011	
NAME OF I	PROVIDER OR SUPPLIER		B. WING STREET	ADDRESS, CITY, STATE, ZIP O	. CODE		
		EHABILITATION CENTER		ALL ST ARAISO, IN46383			
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	DRRECTION	(X5)	
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLETION DATE	
	current, indi	cated "Restraint					
	use will be c	onsidered only					
	after less res	trictive measures					
	have failed,	and the					
	interdisciplii	nary team					
	determines t	hat they are need to					
	treat residen	t (s) medical					
	symptoms	A physical restraint					
	assessment v	will be completed					
	prior to the initiation of a						
	restraintTh	ne use of physical					
	restraint will	be discussed with					
	the resident	(if able), family					
	member* 1	Restraints cannot					
	be used beca	use of a family					
	request in th	e absence of a					
	medical sym	ptomThe care					
	plan will be	updated to include					
	reason for re	estraint use and					
	reduction pla	ans"					
	3.1-3(w)						
	3.1-26(a) 3.1-26(g)						
	3.1-20(g)						

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING		COMPLE	ETED
		155166	B. WING			03/15/20)11
NAME OF B	AD CAMPED OF GLIPPA IED			STREET A	ADDRESS, CITY, STATE, ZIP CODE	l	
NAME OF P	PROVIDER OR SUPPLIER			606 WA	ALL ST		
		EHABILITATION CENTER			RAISO, IN46383		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TΕ	COMPLETION
TAG	1	LSC IDENTIFYING INFORMATION)	F00	TAG	DETERMET)	-	DATE
F0225		review and interview, the	F022	25	F225		04/15/2011
SS=D	_	investigate and report an				,	
	_	se to the Indiana State			INVESTIGATE	/	
	•	ealth (ISDH) timely and			REPORT		
		he residents of the					
		tected for further abuse			ALLEGATIONS	S/	
	for 1 of 24 residents reviewed in a sample of 24. (Resident E)						
					INDIVIDUALS		
					The facility must not employ		
	Findings include	:			individuals who have been found		
					guilty of abusing, neglecting, or		
	Resident E's reco	ord was reviewed on			mistreating residents by a court o		
	3/10/11 at 9 a.m.	Resident E's diagnoses			law; or have had a finding entered into the State nurse aide registry	d	
	included, but wer	_			concerning abuse, neglect,		
		congestive heart failure,			mistreatment of residents or		
	and convulsions.	vongestri i neuro iuniure,			misappropriation of their property	y;	
	una convaisions.				and report any knowledge it has	of	
	A Quarterly Mini	imum Data Set (MDS)			actions by a court of law against	an	
		ed 2/4/11, indicated the			employee, which would indicate	,	
					unfitness for service as a nurse ai	de	
	resident's cogniti				or other facility staff to the State nurse aide		
	(cognition intact)).			registry or licensing authorities	s.	
	Double of the first	71 Parishar F. 2/10/11					
		with Resident E, on 3/10/11 at cated the staff treated her "ok."			The facility must ensure that a	II	
		ff member has ever been mean			alleged violations involving		
	-	indicated "one, she's gone."			mistreatment, neglect, or abus including injuries of unknown	se,	
		was ok now, she indicated			source and misappropriation of	of	
	"yes."				resident property are reported		
					immediately to the administrat	or	
		with Resident E, on 3/10/11 at			of the facility and to other offic	ials	
		ed she reported the aide to			in accordance with State law	_	
		couple days after if happened			through established procedure (including to the State survey)		
	and she said she would take care of it. She indicated it happened around Christmas but could				certification agency).		
		it happened. She indicated the					
					The facility must have evidence	e	

IDENTIFICATION NUMBER: 155166 NAME OF PROVIDER OR SUPPLIER VALPARAISO CARE AND REHABILITATION CENTER VALPARAISO, IN46383 SIRRETADDRESS, CITY, STATE, ZIPCODE 606 WALL ST VALPARAISO, IN46383 (X4) D SIMMANY STATEMENT OF DESCRIPTION INFORMATION 1 TAG REGULATORY OR LED DESTIFYING INFORMATION 1 TAG aide was taken off her hall. The resident's record lacked any documentation in the Social Services Notes or Nurses Notes regarding the allegation. During an interview with Social Service #4 , on 3710/11 at 11:21 a.m., she indicated "1 vaguely remember having a complaint about verbal abuse from (CNA #3) incomplaint about (CNA #3). The resident is about verbal abuse from (CNA #3). The remember her complaining about her rushing with care. I'm sure 1 spoke with (CNA #3) about that. I don't remember. If there was an allegation of abuse, you don't just move them off the hall, I don't remember. If there was an allegation of abuse, you don't just move them off the hall, you would do an investigation. inform low, all k with the resident and get statements, and the CNA would be suspended pending an investigation." During an interview with the DoN, on 31/0/11 at 11:57 a.m., she indicated "I may have taken (CNA #3) about that." During an interview with the DoN, on 31/0/11 at 11:57 a.m., she indicated "I may have taken (CNA #3) about that." During an interview with the DoN, on 31/0/11 at 11:57 a.m., she indicated and the bear remeated of the schedule, staff interviewed and Executive Director would have been remeated of the service of Nursing Services/designee on the Abuse Policy and Reporting by 4/15/11. What measures will be put into place or what systemic changes	STATEMEN	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
NAMI-OF PROVIDER OR SUPPLIER VALPARAISO CARE AND REHABILITATION CENTER VALPARAISO, IN46383 SIMMARY STATEMENT OF DEFICIENCES (I/ACIT DEFECTINCY MIST BE PERCEDED BY YELL. TAG REGULATORY OR I.S. IDENTIFYING INFORMATION) aide was taken off her hall. The resident's record lacked any documentation in the Social Services Notes or Nurses Notes regarding the allegation. During an interview with Social Service #4, on 3/10/11 at 11:21 am, she indicated "I vaguely remember having a complaint about (CNA #3). Let me see if I can find anything about it." During an interview with Social Service #4, on 3/10/11 at 11:37 a.m., she indicated "I have no record about this, I don't remember her complaining about her rushing with care. I'm sure I spoke with (CNA #3) about that." During an interview with the West Unit Manager, on 3/10/11 at 11:37 a.m., she indicated "I have no investigation, inform DoN, talk with the resident and get statements, and the CNA would be suspended pending an investigation of abuse, you don't just move them off the hall, you would do an investigation, inform DoN, talk with the resident and get statements, and the CNA would be suspended pending an investigation." During an interview with the DoN, on 3/10/11 at 11:57 a.m., she indicated she did not know anything about an allegation of abuse. She indicated "Social Service (#4) should have immediately reported itshe client follow our policy. The CNA would have been notified immediately." During an interview with Resident E, on 3/10/11 at 11:21 p. pm., she indicated CNA 3 yelled at her "don't be so picky" and then and [***] you." "I what measures will be put into	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DAVIS DIDIC		COMPLETED	
STREET ADDRESS, CITY, STATE, ZIP CODE 606 WALL ST VALPARAISO CARE AND REHABILITATION CENTER ON JUNEARY STATEMENT OF DEFICIENCES PRIFITY (IACCI DIFFICUNCY MUST IR PERCEIDED BY PULL aide was taken off her hall. The resident's record lacked any documentation in the Social Services Notes or Nurses Notes regarding the allegation. During an interview with Social Service #4, on 3/10/11 at 11.21 a.m., she indicated "I vaguely remember having a complaint about (COM #3). Let me see if I can find anything about it." During an interview with Social Service #4, on 3/10/11 at 11.47 a.m., she indicated "I waguely remember having a complaint about her rushing with care." Im sure I spoke with (CNA #3). I remember her complaint about verbal abuse from (CNA #3). I remember her complaint about verbal abuse from (CNA #3). I remember her complaint about her rushing with care. I'm sure I spoke with (CNA #3) about that." During an interview with the West Unit Manager, on 3/10/11 at 11.47 a.m., she indicated "I may lave taken (CNA #3) of the hall, I don't remember her off the hall, you would do an investigation, inform DoN, talk with the resident and get statements, and the CNA would be suspended pending an investigation of abuse. She indicated "Social Service #4) should have mimediately reported in the suspended pending an investigation of abuse. She indicated "Social Service #4) should have mimediately reported in the rushing with care. I'm sure I spoke with (CNA #3) about that." During an interview with the resident and get statements, and the CNA would be suspended pending an investigation of abuse. She indicated "Social Service #4) should have mimediately reported in the se picky? when the properties are properties as a statement and the CNA would be suspended pending an investigation of abuse. She indicated "Social Service #4) should have mimediately reported its. she didn't follow our policy. The CNA would have been removed off of the schedule, staff inserviewed and Executive Director would have been notified immedia			155166	I		03/15/2011	
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was eating in my room and nad asked ner to put place or what systemic changes					-	I	
		was eating in my ro	oom and nad asked her to put		place or what systemic change	es	

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING		COMPL	
		155166	B. WIN			03/15/20	U11
NAME OF I	PROVIDER OR SUPPLIEF	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TWINE OF I	NO VIDER OR SOIT EIEI			606 WA	ALL ST		
		EHABILITATION CENTER			RAISO, IN46383	_	
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TΕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		the table. She got pulled out of			you will make to ensure that the		
	1	2), she overheard her. (CNA#			deficient practice does not recui	ſ	
	l '	to take care of me and she was					
		e days later she came back and			All staff will be inserviced		
		'f' word, but she was not			monthly on the Abuse Policy at the	ne	
	directing it toward i	me, I didn't feel threatened."			all staff meeting by the		
	Description of the control of the co	DNI #2 2/10/11 2			SDC/designee ongoing.	nda	
		w with RN #2, on 3/10/11 at 2			During Customer Care rou regidents will be interviewed.	nas	
		"I pulled (CNA #3) out of			residents will be interviewed routinely regarding any concerns		
	l '	n because I could tell she was ecause she couldn't figure out			regarding resident's rights and ab		
		g. (Resident E) was eating in			Findings will be documented on		
		CNA #3) say I don't know what			Daily Rounds Checklist and	tiic	
		vitched another CNA, told			addressed immediately.		
		break to calm down. I did not			· The Daily Rounds Checkli	sts	
	1 '	e or yell at (Resident E). I just			will be reviewed during daily		
	1 '	ng by the door. I am not sure			meetings by the ED/designee for		
		was that I had her switch with.			compliance.		
		what day this happened. I told					
		ager so she would know why I					
		ound for that meal. (Resident			How the corrective action(s) wil	1	
	E) was trying to cor	mmunicate about her food and I			be monitored to ensure the		
	don't believe there v	was any abuse, otherwise I			deficient practice will not recur	,	
	would have remove	ed the CNA and reported it."			i.e., what quality assurance		
					program will be put into place		
		w with the Executive Director,				,	
		o.m., he indicated the first time			An "Abuse Prohibition ar	ıd	
	he heard about the a	allegation of abuse was today.			Investigation" CQI tool will be		
	D. I. C.I. COLA				utilized weekly x 4, then monthl	y	
		staffing assignments, indicated			thereafter.	the	
		signed to take care of Resident			Data will be submitted to CQI Committee for review and	uie	
	E after 12/29/10.				follow up.		
	Review of CNA #2!	's employee file, on 3/10/11 at			· Action plans will be		
		she resigned on 1/27/11.			developed as needed for issues		
	i i a.iii., ilidicated s	one resigned on 1/2//11.			identified to improve complianc	e.	
	During an interview	w with the DoN, on 3/10/11 at 3			mp. ove compliant		
		she was going to go interview					
		the investigation. "I do not					
		to residents that way; they					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155166		(X2) M A. BUII B. WIN	LDING	NSTRUCTION	(X3) DATE S COMPL 03/15/2	ETED	
	PROVIDER OR SUPPLIEF	EHABILITATION CENTER	p. (v.a.)	STREET A	DDRESS, CITY, STATE, ZIP CODE LL ST RAISO, IN46383		
				L .	(AISO, 11146363		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	need to be profession	onal and polite."					
	During an interview on 3/11/11 at 4:15 preally good, but Mothe end of last year somewhere around the DoN for the aid. There have been not A facility policy titl Reporting, And Inv 2010, indicated "I allegations/abuse m Executive Director AbuseProcedure: and/or Director of N report and the initia The Executive Dire is responsible for not Department of Heal Director or the Indiana within five (5) work	with the resident's daughter, o.m., she indicated "the staff are om had an issue with an aide at or the beginning of this year, there. I called and spoke with the to be taken off her hall. "further issues." ed," Abuse Prohibition, estigation," dated February Policy/Procedure5. All abuse that the temperature of the immediatelyResident4. The Executive Director Nursing will be notified of the tion of the investigation14. Cotor and/or Director of Nursing of tifyingIndiana State lith16. The Executive exter of Nursing is responsible vestigation processes, assure as ete written record of the gation, and to file up a written a State Department of Health					

STATEMEN	li é			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING		COMPL	ETED
		155166	B. WING			03/15/20	011
			B. WII.		ADDRESS, CITY, STATE, ZIP CODE	l	
NAME OF P	ROVIDER OR SUPPLIER		606 WALL ST				
	AISO CARE AND RI	EHABILITATION CENTER		VALPA	RAISO, IN46383		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0226	Based on record	review and interview, the	F02	26	F226		04/15/2011
SS=D	facility failed to	follow the facility's					
	policy for investi	igating and reporting to			DEVELOP/IMP) L	
	the Indiana State	Department of Health				_	
	(ISDH) an allega	ation of abuse, for 1 of 24			EMENT		
		ed for abuse in a sample			ABUSE/NEGL	E	
	of 24. (Resident	#E)			CT, ETC		
	Findings include	:			POLICIES		
	Reporting, And Inve	ed," Abuse Prohibition, estigation," dated February Policy/Procedure5. All abuse			The facility must develop and implement written policies and procedures that prohibit		
	_	ust be reported to the immediatelyResident			mistreatment, neglect, and about of residents and misappropriate		
		4. The Executive Director			of resident property. What		
		Sursing will be notified of the tion of the investigation14.			corrective action(s) will be accomplished for those		
	_	ctor and/or Director of Nursing			residents found to have beer	ո	
		otifyingIndiana State			affected by the deficient		
	_	th16. The Executive			practice · There is no		
	Director or the Director	ctor of Nursing is responsible			corrective action for resident #		
		estigation processes, assure as			since the alleged deficiency w	as	
		ete written record of the			in the past. How will you identify other residents having	,,	
	-	gation, and to file up a written			the potential to be affected b	- 1	
	•	State Department of Health			the same deficient practice a	·	
	within five (5) work	ing uays.			what corrective action will be		
	Resident E's reco	ord was reviewed on			taken. All residents have the	•	
		Resident E's diagnoses			potential to be affected by th		
	included, but we	_			alleged deficient practice.	All	
	·	,			staff will be educated by the		
	,	congestive heart failure,			Director of Nursing		
	and convulsions.				Services/designee on the Abuse Policy and Reporting	hv	
					4/15/11. What measures will	- 1	
	,	imum Data Set (MDS)			be put into place or what		
	Assessment, date	ed 2/4/11, indicated the			systemic changes you will		
					- -		

STATEMEN	MENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		nn.c		COMPL	ETED
		155166	A. BUIL			03/15/2	011
		100.00	B. WING			00/10/2	
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
				606 WA			
	AISO CARE AND R	REHABILITATION CENTER		VALPAF	RAISO, IN46383		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	resident's cognit	ive score was 15			make to ensure that the		
	(cognition intact	+)			deficient practice does not		
	(cognition intuct	·)·			recur · All staff will be		
	Di				inserviced monthly on the		
	_	w with Resident E, on 3/10/11 at			Abuse Policy at the all staff		
		icated the staff treated her "ok."			meeting by the SDC/designe	е	
		aff member has ever been mean			ongoing. · During Custome	•	
		e indicated "one, she's gone."			Care rounds residents will b	e	
	,	g was ok now, she indicated			interviewed routinely regard	ing	
	"yes."				any concerns regarding	-	
					resident's rights and abuse.		
		w with Resident E, on 3/10/11 at			Findings will be documente	d	
		ed she reported the aide to			on the Daily Rounds Checkli		
		a couple days after if happened			and addressed immediately.		
		ould take care of it. She			The Daily Rounds Checklists		
		ed around Christmas but could			will be reviewed during daily		
		it happened. She indicated the			meetings by the ED/designe		
	aide was taken off	her hall.			for compliance. How the		
					corrective action(s) will be		
		rd lacked any documentation in			monitored to ensure the		
		Notes or Nurses Notes			deficient practice will not red	cur.	
	regarding the allega	ation.			i.e., what quality assurance	,	
	<u>.</u>	:1.0 :10 : "4			program will be put into place	:e	
	_	v with Social Service #4, on			· An "Abuse Prohibition and		
		m., she indicated "I vaguely			Investigation" CQI tool will b		
		complaint about (CNA #3).			utilized weekly x 4, then		
	Let me see if I can	find anything about it."			monthly thereafter. Data wi	II	
	<u> </u>	:4.0 :10 : "4			be submitted to the CQI		
		v with Social Service #4, on			Committee for review and		
		n., she indicated "I have no			follow up. · Action plans wil		
		don't remember her complaint			be developed as needed for	-	
		from (CNA #3). I remember			issues identified to improve		
		out her rushing with care. I'm			compliance.		
	sure I spoke with (0	CNA #3) about that."					
	During an interview	w with the West Unit Manager,					
	_	a.m., she indicated "I may					
		3) off the hall, I don't					
		was an allegation of abuse, you					
		m off the hall, you would do an					
	, ,	, , ,					

PRINTED: 04/15/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155166			LDING	NSTRUCTION	(X3) DATE S COMPL 03/15/2	ETED
	PROVIDER OR SUPPLIEF	EHABILITATION CENTER	 STREET A	DDDRESS, CITY, STATE, ZIP CODE LLL ST RAISO, IN46383		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR investigation, infort	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) n DoN, talk with the resident	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	suspended pending During an interview 11:57 a.m., she indi anything about an a indicated "Social So immediately reporte policy. The CNA w the schedule, staff in Director would have	with the DoN, on 3/10/11 at cated she did not know llegation of abuse. She ervice (#4) should have ad itshe didn't follow our would have been removed off of interviewed and Executive as been notified immediately."				
	12:10 p.m., she indi "don't be so picky" was eating in my ro my bag of chips on my room by (RN #2 3) came back later t nice then. A couple was still saying the	with Resident E, on 3/10/11 at cated CNA #3 yelled at her and then said "f*** you." "I om and had asked her to put the table. She got pulled out of 2), she overheard her. (CNA # to take care of me and she was a days later she came back and 'f' word, but she was not me, I didn't feel threatened."				
	p.m., she indicated (Resident E's) room getting frustrated be what she was saying her room. I heard (you want. I then sw (CNA #3) to take a hear (CNA #3) curs happened to be goir who the other CNA I do not remember to the West Unit Mana switched people arc E) was trying to come getting the compact of the was trying to compact th	with RN #2, on 3/10/11 at 2 'I pulled (CNA #3) out of because I could tell she was cause she couldn't figure out g. (Resident E) was eating in CNA #3) say I don't know what witched another CNA, told break to calm down. I did not e or yell at (Resident E). I just ng by the door. I am not sure was that I had her switch with. what day this happened. I told ger so she would know why I mund for that meal. (Resident municate about her food and I was any abuse, otherwise I				

NAME OF PROVIDER OR SUPPLIER VALPARAISO CARE AND REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 606 WALL ST VALPARAISO, IN46383 (X5)		T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CO LDING	ONSTRUCTION	(X3) DATE S COMPL	ETED
WALPARAISO CARE AND REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) would have removed the CNA and reported it." During an interview with the Executive Director, on 3/10/11 at 2:25 p.m., he indicated the first time he heard about the allegation of abuse was today. Review of the CNA staffing assignments, indicated CNA #3 was not assigned to take care of Resident E after 12/29/10. Review of CNA #3's employee file, on 3/10/11 at 11 a.m., indicated she resigned on 1/27/11. During an interview with the DoN, on 3/10/11 at 3 p.m., she indicated she was going to go interview Resident E and do the investigation. "I do not allow staff to speak to residents that way; they need to be professional and polite." During an interview with the resident's daughter, on 3/11/11 at 4:15 p.m., she indicated "the staff are really good, but Mom had an issue with an aide at the end of last year or the beginning of this year, somewhere around there. I called and spoke with the DoN for the aide to be taken off her hall. There have been no further issues." This federal tag relates to complaint IN00087434.			155166				03/15/2	011
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		During an interview on 3/10/11 at 2:25 p he heard about the a Review of the CNA CNA #3 was not ass E after 12/29/10. Review of CNA #3's 11 a.m., indicated si During an interview p.m., she indicated si Resident E and do the allow staff to speak need to be profession. During an interview on 3/11/11 at 4:15 p really good, but Monthe end of last year of somewhere around the DoN for the aided There have been no.	with the Executive Director, .m., he indicated the first time llegation of abuse was today. staffing assignments, indicated signed to take care of Resident semployee file, on 3/10/11 at the resigned on 1/27/11. with the DoN, on 3/10/11 at 3 she was going to go interview the investigation. "I do not to residents that way; they nal and polite." with the resident's daughter, .m., she indicated "the staff are in had an issue with an aide at the beginning of this year, there. I called and spoke with the to be taken off her hall. further issues."					

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE CC	CONSTRUCTION (X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING		COMPLETED	
		155166	B. WIN		03/15/2011		
NAME OF E	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	!	
TWINE OF I	ROVIDER OR SOLITEIER			606 WA			
VALPAR	AISO CARE AND RI	EHABILITATION CENTER		VALPAI	RAISO, IN46383		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	*	CY MUST BE PERCEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
F0253		ation and interview, the	F02	53	F253 HOUSEKEEPING/MAINTENANCI	04/15/2011	
SS=E		maintain a clean and			The facility must provide		
		ronment on 2 of 2 units			housekeeping and maintenance		
	· ·	Init), related to, dirt and			services necessary to maintain a		
		n along the base boards			sanitary, orderly and comfortable		
	on 4 halls of the	West Unit (Front, Vent,			interior.		
	Viking, and Sout	h hall), which could			What corrective action(s) will be	<u> </u>	
	affect 79 resident	ts who reside on the West			accomplished for those residents	.	
	Unit, a missing p	siece of linoleum in the			found to have been affected by t	I	
	floor of room 219	9, chrome cover off of			deficient practice		
	the bedside table	and dirty feeding tube					
		, scratches and indents			Baseboards have been cleaned. The linoleum in Room 2	210	
	*	and dirty commode			was replaced. The over bed table	I	
		bathroom of 239, dirty			Room 213 was replaced. Toilet s	I	
		in rooms 205, 297, and			in room 239 was replaced. Priva	.	
		coilet seat riser in the			curtains were cleaned for rooms 2		
	_	n 107 on the East Unit,			205, 207. The toilet riser in room	I	
		ct 43 residents who			107 was cleaned. All feeding pol	les	
	resident on the E				have been cleaned.		
	resident on the E	ast Offic.			How will you identify other		
	Pin din an in d. da				residents having the potentia	al	
	Findings include	:			to be affected by the same		
					deficient practice and what		
	During the enviro				corrective action will be take	n	
		a.m. through 10:20 a.m.,			· All residents have the		
		ance Supervisor and the			potential to be effected by th alleged deficient practice.	e	
		apervisor, the following			All staff will be inservice.	ed	
	was observed:				on the use of maintenance		
					requests by 4/15/11.		
	1) West Unit:				The housekeeping staff	will	
					be inserviced on the use of		
	A) There was an	accumulation of dust			cleaning schedules by 4/15/11		
	,	e base boards of both			What measures will be put into		
	_	vays on the Front, Vent,			place or what systemic change	es	
		2 2 2 2			you will make to ensure that the	ne	

STATEMEN	MENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	LDING		COMPL	ETED	
		155166	B. WIN			03/15/2011		
			B. WIIV		ADDRESS CITY STATE ZIB CODE			
NAME OF I	PROVIDER OR SUPPLIEF	₹		STREET ADDRESS, CITY, STATE, ZIP CODE 606 WALL ST				
\/A	AICO CADE AND D	ELIADU ITATION CENTED		1				
VALPAR	AISO CARE AND R	EHABILITATION CENTER		VALPAI	RAISO, IN46383			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	Viking, and Sout	th hall on the West Unit.	I		deficient practice does not rec	ur		
	During an interv	iew at the time of the			· The Housekeeping/Laur			
	_				Supervisor will complete rando	om		
		Housekeeping Supervisor			room checks weekly.			
	I	ust mop the hallway daily.			· The Maintenance			
	She indicated the	ey use the buffer and wet			Supervisor/designee will			
	mop weekly.				complete rounds monthly and repair areas as needed.			
					repair areas as riceded.			
	 During an interv	riew on 03/09/11 at 2:15			How the corrective action(s) w	/ill		
	_				be monitored to ensure the			
	1 *	istrator indicated when			deficient practice will not recui	r,		
	1 *	r buffer, the dirt spreads			i.e., what quality assurance			
		. He indicated he had			program will be put into place			
	informed the Ho	usekeeping Department a						
		he baseboard needed			The Housekeeping/Laun			
	cleaned.				Supervisor will document findi	ngs		
	Cicarica.				on the Quality Control Inspection form.			
	D) TI				The Maintenance			
	·	piece of linoleum missing			Supervisor will document findi	nas		
	out of the floor u	under bed A in room 219.			and repairs in the Preventative	- 1		
					Maintenance Manual.			
	During an interv	iew at the time of the			The Executive			
	_	Maintenance Supervisor			Director/designee will review t	he		
		unaware of the missing			information monthly to ensure			
	linoleum.	diaware of the imissing			compliance.			
	illioleull.				Data will be submitted t			
					the CQI Committee for review			
	l '	over the bed table with			and follow up.			
	missing chrome	on the base of the table			 Action plans will be developed as needed for issue 	_		
	and a feeding tul	be pole with a light			identified to improve complian			
	_	ostance on the base of the			lacitation to improve compliant	· .		
	pole in room 213							
	Poic in 100iii 213	,						
	D	in a dia dia 2						
		iew at the time of the						
	· ·	Maintenance Supervisor						
	indicated the tab	le needed thrown out and						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155166		A. BUII	LDING	NSTRUCTION	COMPI 03/15/2	ETED	
		1.55166	B. WIN	_	DDBECC CITY CTATE ZIP CORE	00/10/2	
NAME OF I	PROVIDER OR SUPPLIE	R		606 WA	DDRESS, CITY, STATE, ZIP CODE		
	AISO CARE AND R	REHABILITATION CENTER			RAISO, IN46383		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· ·	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	πE	COMPLETION DATE
IAG	 	ng Supervisor indicated	+	IAG			DATE
	1	needed cleaned.					
	l the reeding pole	needed cleaned.					
	D) The bathroor	m in room 239, the toilet					
	^	es and indentations and					
		empty commode buckets					
		tored under the sink in the					
	bathroom.						
	During the inter	view at the time of the					
	_	Housekeeping Supervisor					
	indicated the toi	let usually has another					
	toilet seat that ro	olls over the toilet.					
	E) There were b	prown spots on the privacy					
	curtains in room	247, beds A and B.					
	During an interv	view at the time of the					
	observation, the	Housekeeping Supervisor					
	indicated the cur	rtains are washed yearly or					
	more often if ne	eded. She indicated they					
	are suppose to c	heck the curtains daily					
	when they clean	the room.					
	· 1	prown spots on the privacy					
	curtain in room	205, bed B.					
	· ·	brown spots on the					
	privacy curtain i	in room 207, bed A.					
)						
	2) East Wing:						
	A) The toilet mi	iser in the bathroom of					
	A) The toilet ri	isei in the dathroom of					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155166		(X2) MULTIPLE CC A. BUILDING B. WING	NSTRUCTION		E SURVEY PLETED 2011	
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	STREET A	ADDRESS, CITY, STATE, ZIP CO ALL ST RAISO, IN46383	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	107 had a dried to back of the toilet	red substance all over the t seat.				
	observation, the	iew at the time of the Housekeeping Supervisor om had already been				

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155166	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/15/2011	
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 606 WALL ST VALPARAISO, IN46383				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		Ē	(X5) COMPLETION DATE
F0282 SS=D	Based on obreview, and facility failed resident's plate physician's of followed related checks, insurbehavioral in laboratory teresidents revidents revidents revidents of 24 residents N) Findings Inc. 1. Resident	servation, record interview, the d to ensure each an of care and orders were ated to blood sugar lin administration, and ests, for 2 of 24 riewed for aysician's orders care in a sample of (Residents F and lude: F's record was	F02	82	F282 SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged the facility must be provided by qualified persons in accordance weach resident's written plan of care What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice There are no corrective actions for Resident #F and Resident #F and Resident #F and Resident practice is in the past. How will you identify other residents having the potential to affected by the same deficient practice and what corrective action will be taken Residents with physician orders have the potential to be affected by the alleged deficient practice. Licensed nurses will be re-educated on following	rith re. e s he	04/15/2011
	a.m. Reside included, bu				physician orders by the DNS/designee by 4/15/11. What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur The Interdisciplinary Teareviews the physician orders a	am	

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155166	A. BUI	LDING		COMPLETED 03/15/2011	
		133100	B. WIN			03/13/2011	
NAME OF I	PROVIDER OR SUPPLIER			606 WA	ADDRESS, CITY, STATE, ZIP CODE		
VALPAR	AISO CARE AND R	EHABILITATION CENTER		1	RAISO, IN46383	_	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	``	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE	
	recapitulation, dated 3/11, indicated "11/27/10 accu				the clinical meeting (Mon-Fri). The Interdisciplinary Te	am	
					reviews the Lab Tracking Log	at	
	checks (bloc	d sugar checks)			the clinical meeting (Mon-Fri). The Unit		
	three times of	laily10/19/10			Manager/designee will audit the Capillary Blood Glucose	ne	
	Novolog (in	sulin)inject sub-q			Monitoring Tool daily (Mon – F		
	(subcutaneo	usly) per sliding			excluding holidays) to monitor compliance with physician ord		
	scale (admin	istered per blood			How the corrective action(s)		
	sugar result)	: 70-150 = 0 units,			will be monitored to ensure t	:he	
	151-200=2	units, $201-250 = 4$			deficient practice will not rec	cur,	
	units, 251-30	,			i.e., what quality assurance program will be put into place	e	
	ĺ	inits, 351-400= 10					
		ater than) 400 call			A "Medication Administration" and		
	MD. 12/9/1	<i>'</i>			"Labs/Diagnostics" CQI tool w	ill	
					be utilized weekly x 4, then monthly thereafter.		
	` ′ ′	ject 15 units sub-q			Data will be submitted	· ·	
		ime. 12/9/10			the CQI Committee for review and follow up.	'	
	Lantusinje	ct 15 units sub-q			· Noncompliance with fac	cility	
	daily in the i	morning."			procedures may result in disciplinary action.		
					a.co.p.mar.y dollori.		
	A blood glue	cose monitoring					
	tool, dated 1	2/10, indicated					
		s were to be done					
	three times a day at 6 a.m., 4						
		o.m. The form					
	indicated the following blood						
	sugar results):					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155166		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED 03/15/2011		
	PROVIDER OR SUPPLIER		B. WINC	STREET A	ADDRESS, CITY, STATE, ZIP CODE LLL ST RAISO, IN46383	100.10.2	<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	12/1/10 at 9	p.m., 253 and the					
	Lantus insulin was						
	administered	d but no novolog					
	insulin was a	administered per					
	the sliding s	cale.					
	12/5/10 at 9	p.m., 212 and the					
	Lantus insul	in was					
	administered	d but no novolog					
	insulin was a	administered per					
	the sliding s	cale.					
	12/7/10 at 9	p.m., 218 and no					
	novolog inst	ılin was					
	administered scale.	l per the sliding					
	12/8/10 at 9	p.m., 209 and the					
	Lantus insul	•					
	administered	d but no novolog					
		administered per					
	the sliding s	-					
		p.m., 232 and 8					
		olog insulin was					
		d instead of the 4					
	units as orde						
	12/12/10 at 9	9 p.m., 282 and the					
	Lantus insul	-					

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPI	LETED
		155166	B. WI			03/15/2	2011
	PROVIDER OR SUPPLIER	EHABILITATION CENTER		606 WA	DDRESS, CITY, STATE, ZIP CODE LL ST RAISO, IN46383	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE .	(X5) COMPLETION DATE
		l but no novolog					
		administered per					
	the sliding so						
		9 p.m.,183 and the					
	Lantus insul						
		l but no novolog					
		administered per					
	the sliding so						
		9 p.m., 214 and the					
	Lantus insul						
	administered	l but no novolog					
	insulin was a	administered per					
	the sliding so						
	12/18/10 at 9	9 p.m., 176 and the					
	Lantus insul	in was					
	administered	l but no novolog					
	insulin was a	administered per					
	the sliding so	cale.					
	12/21/10 at 9	9 p.m., 249 and the					
	Lantus insul	in was					
	administered	l but no novolog					
	insulin was a	administered per					
	the sliding so	cale.					
	12/24/10 at 9	9 p.m., 232 and the					
	Lantus insul	in was					
	ļ						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE S	ETED	
		155166	B. WIN			03/15/20	011
NAME OF I	PROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP CODE		
VALPARA	AISO CARE AND RI	EHABILITATION CENTER	606 WALL ST VALPARAISO, IN46383				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION DATE
	administered	l but no novolog					
	insulin was a	administered per					
	the sliding so	cale.					
	12/25/10 at 9	9 p.m., 251 and the					
	Lantus insul	in was					
	administered	l but no novolog					
	insulin was a	administered per					
	the sliding so	cale.					
	A blood gluc	cose monitoring					
	tool, dated 1	/11, indicated the					
	blood sugars	were to be done					
	three times a	day at 6 a.m., 4					
	p.m., and 9 p	o.m. The form					
	indicated:						
	1/1/11, no bl	ood sugar check or					
	sliding scale	insulin					
	administration	on at 6 a.m.					
		ood sugar check or					
	sliding scale	•					
	administration						
		ood sugar check or					
	sliding scale	•					
	administration						
		ood sugar check or					
	1, 110 01						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,		NSTRUCTION	(X3) DATE SURVEY COMPLETED		
		155166	A. BUILDING B. WING			03/15/2011	
NAME OF I	PROVIDER OR SUPPLIER		!		DDRESS, CITY, STATE, ZIP CODE	1	
VALPARA	AISO CARE AND R	EHABILITATION CENTER	606 WALL ST VALPARAISO, IN46383				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIADEFICIENCY)	NTE.	(X5) COMPLETION DATE
1/10	sliding scale	· · · · · · · · · · · · · · · · · · ·		mo			DAIL
	administration						
		blood sugar check					
	or sliding sc	•					
	administration						
		blood sugar check					
	or sliding sc	•					
	administration						
		blood sugar check					
	or sliding sc	C					
	administration						
		blood sugar check					
	or sliding sc						
	administration						
	 1/19/11, no 1	blood sugar check					
	or sliding sc	•					
	administration						
	1/23/11 at 4	p.m., the resident's					
		results were 314					
	and 4 units of	of novolog insulin					
	was adminis	tered when 8 units					
	should have	been administered					
	per the phys	ician's order.					
	^ ^ ~	blood sugar check					
	or sliding sc	C					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

HNBL11

Facility ID:

000083 If con

If continuation sheet Page 30 of 70

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		155166	B. WIN			03/15/2	2011
NAME OF P	ROVIDER OR SUPPLIEF	* {			ADDRESS, CITY, STATE, ZIP CODE	•	
VALPARA	AISO CARE AND R	EHABILITATION CENTER		606 WA	RAISO, IN46383		
(X4) ID		STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5)
PREFIX TAG	, and the second se	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETION DATE
	administration	on at 9 p.m.					
	1/29/11, no	blood sugar check					
	or sliding sc	ale insulin					
	administration	on at 9 p.m.					
	During an in	nterview on 3/10/11					
	at 9:22 a.m.,	, the West Unit					
	Manager, in	dicated the					
	resident's blo	ood sugar checks					
	and insulin h	nad not been					
	administered	d as ordered by the					
		J					
	r Jana						
	During an in	nterview on 3/10/11					
	at 3 p.m., the	e DNS (Director of					
	•	`					
	_	*					
		_					
		mistration were a					
	111000.						
	2. Resident	N's record was					
		•					
		•					
	ĺ						
	io, depressio	on, hypertension,					
	at 3 p.m., the Nursing Ser resident's ble insulin admirates." 2. Resident reviewed on Resident N's included, but	e DNS (Director of vices) indicated the ood sugars and inistration were a N's record was 3/8/11 at 1:30 p.m.					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			COMPL	LETED	
		155166	B. WING	G		03/15/2	011
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	•	606 WA	DDRESS, CITY, STATE, ZIP CODE LL ST RAISO, IN46383		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	λΤΕ	(X5) COMPLETION DATE
	and epilepsy	·.					
	3/4/11, indic PT/INR Prod International (laboratory to clotting) on a	I normalized ration) lests for blood 3/7/11." 's record lacked on of the PT/INR					
	During an in at 2:10 p.m., the laborator done as order the nurse whorder had no laboratory re-	terview on 3/8/11 RN #9 indicated ry test had not been ered. She indicated no had taken the of completed a equisition for the 3/7/11, so it had					
	_	N's Social Service tes, dated 2/4/11 at					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

HNBL11

Facility ID: 000083

If continuation sheet

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PRINTED: 04/15/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE (ETED	
		155166	B. WIN			03/15/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
VALPARA	AISO CARE AND RI	EHABILITATION CENTER	606 WALL ST VALPARAISO, IN46383				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	COMPLETION DATE
	9 a.m., indicated "Res (Resident) had behavior on						
	2/4/11 at 2:3	0 a. Nrsg					
	(Nursing) ob	served res					
	chewing on	his brief. Nrsg					
	talked c (wit	h) ResWriter					
	discussed c 1	res the health issues					
	involved c re	es placing non-food					
	substance in	his mouthNrsg					
		oth briefs only to					
	res."	J					
	A care plan,	dated 11/16/10,					
	indicated "						
	non-food ite	•					
		roachRes to have					
	cloth briefs						
	CIOUI UIICIS (Jiii y .					
	Resident N v	was observed on					
		13 p.m., and 3/8/11					
		_					
	•	with disposable					
		e briefs on instead					
	of cloth brie	IS.					
	During on in	torvious on 2/9/11					
	During an in	terview on 3/8/11					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

HNBL11 Facility ID:

000083

If continuation sheet

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (CONSTRUCTION	(X3) DATE S COMPL		
111,2 12,11,	or condition,	155166	A. BUILDING B. WING		03/15/2		
NAME OF F	PROVIDER OR SUPPLIER		STREE	Γ ADDRESS, CITY, STATE, ZIP C	ODE		
		EHABILITATION CENTER	606 WALL ST VALPARAISO, IN46383				
(X4) ID		TATEMENT OF DEFICIENCIES	ID	1	i	(X5)	
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A	HOULD BE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE	
	_	RN #9 indicated					
		did not have cloth					
	briefs on.						
		g relates to complaint					
	IN00087434.						
	3.1-35(g)(2)						
	3.1-33(g)(2)						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		155166	B. WING			03/15/20)11
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
VALPARA	AISO CARE AND RE	EHABILITATION CENTER	606 WALL ST VALPARAISO, IN46383				
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE	COMPLETION DATE
F0309	Based on record review and		F03		F309 PROVIDE CARE/SERVICES FOR		04/15/2011
SS=D	interview, the facility failed to				HIGHEST WELL BEING Each resident must receive and the	I .	
	provide the r	necessary care and			facility must provide the necessar care and services to attain or	y	
	services rela	•			maintain the highest practicable		
					physical, mental, and psychosocial well-being, in accordance with the		
		g as needed (prn)			comprehensive assessment and pl		
	*	tion to a resident			of care.		
	who was scre	eaming with pain,			What corrective action(s) will be		
	for 1 of 24 re	esidents reviewed			accomplished for those residents	s	
	for providing	g the necessary			found to have been affected by the deficient practice		
	care and serv	vices in a sample of			dencient practice		
		(Resident #89)			There is no corrective acti	-	
	2 i residents.	(Resident 1109)			for resident #89 since the alleged deficiency was in the past.		
	T' 1'	1 1					
	Findings inc	lude:			How will you identify other residents having the potential to	he	
					affected by the same deficient	, be	
	Resident #89	9's record was			practice and what corrective		
	reviewed on	3/8/11 at 9:23 a.m.			action will be taken		
	Resident #89	9's diagnoses			· All residents have the		
		t were not limited			potential to be affected by the alle	eged	
					deficient practice. Nurses will be educated or	n	
	to, Alzheime	ŕ			assessment and intervention		
	arthritis, and	stroke.			regarding residents in pain by the SDC/designee by 4/15/11.		
					What measures will be put in	to	
	The physicia	n's order			place or what systemic		
		n, dated 3/11,			changes you will make to ensure that the deficient		
	-	order for Tylenol			practice does not recur		
		•			· Unit Manager/designee		
	323 milligrai	ms two tablets			will audit the 24-hour reports		

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		155166	B. WIN			03/15/2011	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
	AISO CARE AND RI	EHABILITATION CENTER		606 WA	RAISO, IN46383		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		X5)
TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	E	LETION ATE
	every 6 hour	s as needed for			daily in clinical meeting (Mon-Fri) for change in		
	pain scale of	f 1-10, dated			resident condition including		
	8/4/10.			pain. Any resident with a			
					change of condition will be reviewed for appropriate		
	Δ nurges' not	te, dated 1/31/11 at			intervention and		
		ŕ			documentation.		
	6 a.m., indic				How the corrective action(s) w	ill	
		eaming upon			be monitored to ensure the deficient practice will not recur		
	movement for	or care et (and)			i.e., what quality assurance	,	
	transfers. Ve	ry stiff in some			program will be put into place		
	joints. MD p	paged."			· A "24 Hour Condition		
	3	C			Report" CQI tool will be utilize	t	
	The MAR (r	nedication			weekly x 4, then monthly thereafter.		
	`				Data will be submitted to		
		on record), dated			the CQI Committee for review and follow up.		
	ŕ	ed the as needed			Noncompliance with fac	ility	
	Tylenol had	not been			procedures may result in disciplinary action.		
	administrate	d when the resident			alcolpiniary dollors.		
	had been yel	lling/screaming in					
	pain.						
	r						
	A physician'	s order dated					
		a.m., indicated					
		ŕ					
	•	ral hips and pelvis					
	DX (diagnos	sis) pain"					
	The x-ray re	sults, dated					

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IULTIPLE COI	NSTRUCTION	COMPI	
		155166	B. WIN			03/15/2	011
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	•	606 WA	DDRESS, CITY, STATE, ZIP CODE LL ST RAISO, IN46383	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
	1/31/11, indi	cated no					
	abnormalitie	S.					
	During an in at 11:25 a.m Manager ind should have as needed pa 1/31/11 at 6 she would chreport sheet had put she l the prn Tyler During an in at 9:22 a.m., Manager ind not any infor hour report for the propert for the prop	terview on 3/8/11 ., the West Unit icated, the nurse administered the in medication on a.m. She indicated neck the 24 hour to see if the nurse had administered					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC		COMPLETED
		155166	1	WING 03/15/2011		
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER			606 WA		
VALPARA	AISO CARE AND RI	EHABILITATION CENTER			RAISO, IN46383	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)	DATE
F0323	Based on record review and interview, the		F03	23	F323 FREE OF	04/15/2011
SS=G	facility failed to ensure a resident received				ACCIDENTS/HAZARDS/ SUPERVISION/DEVICES	
00-0	adequate supervision and assistance to				The facility must ensure that the	ne
		s related to an unsafe			resident environment remains	
	_	ansferring a resident			free of accident hazards as is	
		•			possible; and each resident	
	without the indic				receives adequate supervisior	
	•	resulted in a fracture of			and assistance devices to pre	vent
		, for 1 of 11 residents			accidents This tag is being disputed.	
	reviewed who red	quired the use of a hoyer			This tag is being disputed.	
	lift for transfers in a sample of 24 and				What corrective action(s) wil	ı
	failed to implement fall interventions to				be accomplished for those	
	•	alls for 1 of 7 residents			residents found to have beer	n
	•	s in a sample of 24			affected by the deficient	
		ent #74 and #131)			practice	
	residents. (Reside	cm #74 and #131)				
					· There is no corrective	
	Findings include	:			action for resident #74 and	ـا
	1 D :1 / //7/	1 2/0/11			resident #131 since the allege	a
		ecord was reviewed on 3/8/11			deficiency was in the past.	
		nt #74's diagnoses included, to, traumatic brain injury and			How will you identify other	
	fractured tibia and fi				residents having the potentia	al
	nactarea tibia ana n	iouiu.			to be affected by the same	
	A quarterly MDS (M	Minimum Data Set) assessment,			deficient practice and what	
		ated Resident #74 cognitive			corrective action will be take	n
		d dependent on two staff for				
		er, toilet use and bathing. The			· Residents residing in th	l l
		cked documentation of the			facility have the potential to be	
	resident having falls	s since admission.			affected by the alleged deficie	nt
		0.011.1.1.107070			practice. The SDC/designee will	
		for falls, dated 10/19/10,			complete Inservice for staff on	
	indicated "hoyer lift	anu ∠ Staii"			Fall Prevention Interventions a	l l
	A Resident Care/No.	ed sheet, dated 11/19/10,			the use of Mechanical Lifts by	
		74 required a hoyer lift with			4/15/11.	
	two assist.	required a noyer int with				
	• •••••				What measures will be put in	to
	A Nurses' Note, date	ed 11/20/10 at 10:00 a.m.,			place or what systemic	
		•	1			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

HNBL11

000083

Facility ID:

If continuation sheet

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DINC	NG (COMPLETED	
		155166	B. WIN			03/15/20	011	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	ROVIDER OR SUPPLIER	1		1				
				606 WA				
VALPARA	AISO CARE AND R	EHABILITATION CENTER		VALPAI	RAISO, IN46383			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	re I	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	indicated "CNA's pr	ut res (resident) in bed for rest,	Ī		changes you will make to			
	writer called to roor	n. Res L (left) knee area &			ensure that the deficient			
	(and) outer side c/ (with) 15 cm (centimeters) x				practice does not recur			
		ue bruise et (and) swollen from						
	knee & ankle, warm	to touch but not excessive			· Unit Managers monitor			
					resident care by making round	ls		
		ted 11/20/10 at 1:00 p.m.			on their units. Concerns are			
	indicated the resider	nt was admitted to the hospital.			addressed with the nursing aid	de,		
					as needed. Rounds are completed ea	a a b		
		ical from the hospital, dated			shift by the charge nurse, Mor			
		"Acute fractured tibia and			- Friday, by department heads			
	fibula"				monitor resident care. Conce			
	D: £41 £:1:	tala inaranti antiara manant. Anta d			are addressed with the resider			
		ty's investigative report, dated the CNA providing Resident			charge nurse			
		ed the resident using a hoyer			· utilizing an inservice an	d/or		
		ne wheelchair. The report			disciplinary action.			
	_	did not follow the resident's			· The Director of Nursing			
		wo staff members when using a			Services is responsible to mor	nitor		
	hoyer lift.	wo sum memoers when using u			for facility compliance.			
	noyer mr.				· Unit Managers are			
	During an interview	on 3/8/11 at 1:20 p.m., the			responsible to ensure resident	:s		
	_	ursing) indicated the CNA did			receive the necessary fall			
	· ·	fer policy. The DoN indicated			prevention measures they			
		A "tried to cut corners" and			require. Nursing staff will complete.	ata		
		in the wheelchair by standing			skills validations Mechanical L			
	him up and not usin	g the hoyer lift. The DoN			usage by 4/15/11.			
	-	ENA had seen the resident						
		of his wheelchair and the						
	resident was yelling	The DoN indicated the CNA			How the corrective action(s)			
		hey placed the resident into the			will be monitored to ensure t	he		
	bed they noticed the	e discoloration of the resident's			deficient practice will not rec	ur,		
	leg.				i.e., what quality assurance			
					program will be put into plac	e		
	A professional re	esource, titled, "Indiana						
	State Departmen	t of Health Division of			· Observations will be			
	•	Nurse Aide Training			documented on the "Nursing			
	Program July 19	•			Rounds Checklist" and	.		
		•			"Mechanical Lift Transfers" CC			
	Transferring, ind	iicaicu,4. A			tools weekly x 4, then monthly			
					ı			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING		COMPL	ETED
		155166	B. WIN			03/15/2	011
NAME OF	DDOMDED OF GUIDN 151				ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF I	PROVIDER OR SUPPLIEI	X.		606 WA	ALL ST		
		EHABILITATION CENTER			RAISO, IN46383		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG	-	R LSC IDENTIFYING INFORMATION)	-	TAG			DATE
	mechanical lift				thereafter. Data will be submitted.	to	
	co-worker assist when using a mechanical				the CQI Committee for review		
	lift"				and follow up.		
					· Noncompliance with fa	cility	
	2. Resident #131's record was reviewed				procedures may result in		
	on 3/9/11 at 1:10	p.m. Resident #131's			disciplinary action.		
	diagnoses included, but were not limited						
	to, dementia, bronchitis and hypertension.						
	An admission MDS assessment, dated						
	1/13/11, indicated Resident #131's						
		was intact, required					
	-	ee of one staff member for					
		se and bathing. The					
	1	assessment indicated the					
		en prior to admission and					
	had fractured in						
	nad fractured in	a lall.					
	A fall care plan,	dated 12/13/10, indicated					
	the intervention	to keep the resident's					
	wheelchair at be	dside and easily					
	accessible was a	-					
	A Resident Care	/Need sheet, dated					
		ed 'Place w/c next to bed					
	when res in bed.						
		•••					
	An IDT (Interdis	sciplinary Team) progress					
	`	1, indicated "Fall on					
	· ·	m. Res was in his room in					
	_	from bed, walked over to					
	1	of bed to get his w/c					
		-					
	(wheelchair) &	walked backwards c/ w/c					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155166		(X2) MULTIPLE CO A. BUILDING B. WING	INSTRUCTION	COM	(X3) DATE SURVEY COMPLETED 03/15/2011	
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	606 WA	ADDRESS, CITY, STATE, ZIP CO NLL ST RAISO, IN46383	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
		a buttocks & back hitting kept @ (at) bedside &"				
	p.m., indicated "front of bed on b started c/ neuro a abrasion noted to A Fall Circumsta 2/20/11, indicate for his chair and During an interv p.m., the West H	dated 2/20/11 at 6:00 Res found on floor in outtocks. Fall charting assessmentssmall of L rear thigh" Ince Report, dated do "he said he reached it was not there" iew on 3/9/11 at 2:05 all Unit Manager ident's wheelchair was				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPL	ETED
		155166	B. WIN			03/15/2	011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER			606 WA			
VALPARA	AISO CARE AND RI	EHABILITATION CENTER		l	RAISO, IN46383		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		ļ	TAG	DEFICIENCY)		DATE
F0328	Based on observation, record review, and		F03	28	F328 TREATMENT/CARE FOI	R	04/15/2011
SS=D	interview, the facility failed to ensure				SPECIAL NEEDS The facility		
00-0	oxygen was adm	inistered as ordered by			must ensure that residents		
		1 of 7 residents reviewed			receive proper treatment and		
		ample of 24 residents.			care for the following special services: Injections, parentera	si.	
		ample of 24 residents.			and enteral fluids; Colostomy,	21	
	(Resident #138)				ureterostomy, or ileostomy car	æ.	
	P' 1' ' 1 1				Trachesostomy care; Trachea		
	Findings include:				suctioning; Respiratory care; F		
	Danin a tha initial ta				care; and Prostheses. What		
	During the initial tour with RN#1 on 3/7/11 at 10:30 a.m., Resident #138 was observed laying in her bed. The resident's oxygen was set on 4.5				corrective action(s) will be		
					accomplished for those		
		ted the resident's oxygen was			residents found to have beer	1	
	on 4.5 liters.	tied the resident's oxygen was			affected by the deficient		
	011 1.5 11015.				practice · There is no		
	Resident #138 was o	observed on 3/8/11 at 8:45 a.m.			corrective action for resident #		
		her oxygen level set on 4			since the alleged deficiency wa	as	
	liters.	7.5			in the past. How will you		
					identify other residents having	-	
	Resident #138 was o	observed on 3/8/11 at 1:50			the potential to be affected b	-	
	p.m., with the oxyge	en level set on 4 liters.			the same deficient practice a what corrective action will be		
					taken · Residents who use	*	
	_	on 3/8/11 at 2:38 p.m., RN #1			oxygen have the potential to b	۵	
	indicated the resider	nt's oxygen was set on 4 liters.			affected by the alleged deficien		
	D :1 / //100	1 2/0/11			practice. Licensed nurses ar		
		ord was reviewed on 3/8/11 at			respiratory staff will be		
		t #138's diagnoses included,			re-educated on following		
	hypertension, and de	to, congestive heart failure,			physician orders by the		
	hypertension, and de	epression.			SDC/designee by 4/15/11. Wh		
	A physician's order	dated 4/26/10, indicated the			measures will be put into pla		
	oxygen was 5 liters				or what systemic changes yo	ou	
		r			will make to ensure that the		
	During an interview	on 3/8/11 at 2:43 p.m.,			deficient practice does not	nom	
	•	st #5 indicated the oxygen			recur The interdisciplinary to will review the "24 Hour Repor		
	should be set at 5 lit	ers.			and "Physician Telephone Ord		
					forms for changes in oxygen	401	
	3.1-47(a)(6)				settings Monday – Friday		
ı			1		I		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155166			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/15/2011		
	ROVIDER OR SUPPLIER	EHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 606 WALL ST VALPARAISO, IN46383				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	Ditte		
				(excluding holidays) at the Cli Meeting. The interdisciplinary team determines if any further interventions or changes to the plan of care is necessary. The Respiratory Supervisor/design will ensure compliance. Respiratory Supervisor/design is responsible to ensure compliance with facility proceed for compliance with physician orders. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what qual assurance program will be pinto place Respiratory Supervisor/designee will comple the "Oxygen Therapy" CQI tool times weekly x 4, the once week 4 weeks and then monthly thereafter. Data will be submit to the CQI Committee for reviand follow up. Noncomplian with facility procedures may rein disciplinary action.	e e e e e e e e e e e e e e e e e e e		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155166		(X2) MULTIPLE CONSTRUCTION A. BUILDING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/15/2011		
		133100	B. WIN			03/13/20	011
NAME OF F	PROVIDER OR SUPPLIER	8		606 WA	ADDRESS, CITY, STATE, ZIP CODE		
		EHABILITATION CENTER		VALPAI	RAISO, IN46383		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
F0365		· · · · · · · · · · · · · · · · · · ·	F03				04/15/2011
		ation, record review, and	1 103	03	F365 FOOD IN		04/13/2011
SS=E	interview, the facility failed to provide residents' food in a form designed to meet				FORM TO		
		eds, related to serving			TOKIWI TO		
		meat to residents on a			MEET		
		diet for 2 residents in a			INDIVIDUAL		
	-	sidents #57 and #89) and			_		
		upplemental sample of			NEEDS		
	`	and #62). This had the			Each resident receives and th		
	•	et 12 residents in the			facility provides food prepared a form designed to meet	in	
	facility with physician's orders for a				individual needs. What correc	tive	
	mechanical soft	diet.			action(s) will be accomplished	∍d	
	Pludius atus 1				for those residents found to		
	Findings include				have been affected by the deficient practice • The me	ale	
	Duning on chaom	vation of the avaning			for Resident #57, #89, #49 an		
	_	vation of the evening 1 the following was			#62 were removed and they w		
	observed:	i the following was			given the correct item per the	.	
	ooserved.				Modified Diet Spreadsheet. I will you identify other reside		
	A) At 5:35 n m	in the West Unit dining			having the potential to be		
		89 received her supper,			affected by the same deficien		
	· ·	peef and noodles. The			practice and what corrective		
		in approximate 1/2 inch			action will be taken Residents residing in the facili	itv	
	cubes.	**			have the potential to be affect	-	
					by the alleged deficient practic	ce.	
	During an interv	iew at the time of the			 The Dietary staff was inserv on Mechanical Soft/Ground M 		
	_	Registered Dietician			by the RD on 3/9/11. What	cal	
	Manager indicate	ed the meat was not			measures will be put into pla	ıce	
	ground and she is	ndicated she would			or what systemic changes ye	ou	
	replace the beef	and noodles with the			will make to ensure that the		
	correct diet.				deficient practice does not recur · The Dietary Manage	r	
					will verify food consistency on		
	B) At 5:40 p.m.	resident #57 received her			the meal has been prepared.		

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155166	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE S COMPLE 03/15/20	ETED
		199100	B. WIN			03/13/20	711
NAME OF I	PROVIDER OR SUPPLIEF	₹		1	ADDRESS, CITY, STATE, ZIP CODE		
VALPAR	AISO CARE AND R	EHABILITATION CENTER		606 WA	RAISO, IN46383		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	TE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	diet in the East U	Jnit dining room, which			The Dietary Manager will mon	itor	
included beef and noodles. The beef was				meal service to ensure the Modified Diet Spreadsheet is			
	served in approx	imate 1/2 inch cubes. The			being followed. Monitoring w	ill	
	meat could not b	e cut with a fork.			happen daily (Mon-Fri) for 4		
					weeks, then 3 times weekly x 4		
	Resident #49 rec	eeived her diet in the East			weeks, then weekly x 4 weeks an	ıd	
		n, which included regular			then monthly thereafter. How		
beef and noodles.				the corrective action(s) will b	e		
	0001 4114 1100 4101	•			monitored to ensure the deficient practice will not rec		
	During an interview at the time of the				i.e., what quality assurance	ui,	
	observation, the Registered Dietician				program will be put into plac	e	
	Manager indicated the residents had				· Observations will be		
	_				documented on the "Meal		
	received regular	meat.			Accuracy" CQI tool weekly x		
	G) 4 . 5 50	D :1 . //co.1 . 1			then monthly thereafter. Da	ata	
		, Resident #62 had			will be submitted to the CQI		
		al tray in his room. The			Committee for review and follow up. · Noncompliance		
		l regular beef and			with facility procedures may		
	noodles.				result in disciplinary action.		
		cility's Modified Diet					
	Spreadsheet, date	-					
	201-2011, indica	ated the mechanical soft					
	diets were to rec	eive 6 ounces of ground					
	beef and noodles	5.					
	1 Resident #62'	's record was reviewed on					
	03/08/11 at 6 p.n						
	•	led, but were not limited					
	_	Disease and Congestive					
	heart failure.	Piscase and Congestive					
	neart fallure.						
	The resident's Ph	nysician's Recapitulation					
		/11, indicated an order for					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155166		(X2) MULTIPLE CO	ONSTRUCTION	СОМ	(X3) DATE SURVEY COMPLETED 03/15/2011	
	PROVIDER OR SUPPLIER		606 W	ADDRESS, CITY, STATE, ZIP CO ALL ST IRAISO, IN46383		2011
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
	03/08/11 at 6:05 diagnoses includ to, Alzheimer's I The resident's Ph Orders, dated 03 mechanical soft meats. 3. Resident #49' 03/08/11 at 6:10 diagnoses includ to, Parkinson's D The resident's Ph Orders, dated 03 a mechanical sof 4. Resident #57' 03/07/11 at 2:10 diagnoses includ to, dementia and The resident's Ph Orders, dated 03 a mechanical sof a mechanical sof During an interva.m., the Directo	s record was reviewed on p.m. The resident's ed, but were not limited Disease and stroke. Aysician's Recapitulation /11, indicated an order for second was reviewed on p.m. The resident's ed, but were not limited bisease and convulsions. Aysician's Recapitulation /11, indicated an order for it diet. It is record was reviewed on p.m. The resident's ed, but were not limited historial was reviewed on p.m. The resident's ed, but were not limited hiatal hernia. Aysician's Recapitulation /11, indicated an order for it diet.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155166		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COMI	(X3) DATE SURVEY COMPLETED 03/15/2011			
VALPARA		EHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 606 WALL ST VALPARAISO, IN46383					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	ECTION DULD BE PROPRIATE	(X5) COMPLETION DATE		
	3.1-21(a)(3)							

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155166		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE		(X3) DATE SURVEY COMPLETED 03/15/2011		
NAME OF F	PROVIDER OR SUPPLIER			STREET A		
		EHABILITATION CENTER		VALPAI	RAISO, IN46383	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE
F0367		ation, record review, and	F03	67	F367	04/15/2011
SS=D	· ·	cility failed to provide				_
	-	as ordered by the ian, related to double			THERAPEUTION	•
		ified food for 3 of 7			DIET	
	•	hysician's orders for			PRESCRIBED	
	•	entions in a sample of				
	24. (Residents #2	2, #57, and #74)			BY PHYSICIAN	N
					Therapeutic diets must be	
	Findings include	:			prescribed by the attending physician. What corrective	
	During an observ	vation of the evening			action(s) will be accomplished	ed
	_	the following was			for those residents found to	
	observed:	8			have been affected by the deficient practice • There is	no
					corrective action for resident #	I
	A) At 5:25 p.m.,	resident #74 received his			#57, #74 since the alleged deficiency was in the past. H	0144
		fluids on his tray			will you identify other reside	I
	included two gla	sses of juice.			having the potential to be	
	D) At 5:40 n m	,. resident #57 received			affected by the same deficier practice and what corrective	I
		which included one piece			action will be taken	
		ton of whole milk.			Residents residing in the facili	-
					have the potential to be affected by the alleged deficient practic	
	During an interv	iew at the time of the			The Dietary staff was inservice	ed
	observation, the	Registered Dietician			on Fortified Foods by the RD of 3/9/11. What measures will	I
	_	ed the resident had not			put into place or what system	
		e dessert. She indicated			changes you will make to	
	the fortified food milk.	is put into the resident's			ensure that the deficient practice does not recur	
		e resident had not			Residents receiving fortified for	ods
	received fortified				will have their tray card	
		**			highlighted so that staff will diligent in serving fortified food	ds
	C) At 6:25 p.m.,	resident #2 received her			to the residents. The Dietar	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		155166	B. WIN			03/15/2011	
					ADDRESS, CITY, STATE, ZIP CODE	!	
NAME OF I	PROVIDER OR SUPPLIER			606 WA	ALL ST		
		EHABILITATION CENTER		_	RAISO, IN46383	_	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)	-	TAG		DATE	
	1 1	ich included juice and			Manager will monitor meal service to ensure accuracy.		
water for her supper fluids.					Monitoring will happen daily		
					(Mon-Fri) for 4 weeks, then 3		
	1. Resident #57'	s record was reviewed on			times weekly x 4 weeks, then		
	03/07/11 at 2:10	p.m. The resident's			weekly x 4 weeks and then		
	diagnoses includ	ed, but were not limited			monthly thereafter. How the		
	to, dementia and	hiatal hernia.			corrective action(s) will be		
	-				monitored to ensure the		
	The resident's Ph	ysician's Recapitulation			deficient practice will not red i.e., what quality assurance	cur,	
		/11, indicated an order for			program will be put into place	:e	
		th all meals and double			Observations will be		
	desserts at lunch				documented on the "Meal		
	desserts at fullen	and uniner.			Accuracy" CQI tool weekly x 4		
	2 D				then monthly thereafter. Date	ta	
		s record was reviewed on			will be submitted to the CQI	,,,	
		a.m. The resident's			Committee for review and folloup. Noncompliance with fac		
		ed, but were not limited			procedures may result in	inty	
	to, closed head in	njury and fractured leg.			disciplinary action.		
	The resident's Ph	ysician's Recapitulation					
	Orders, dated 03	/11, indicated an order for					
	fortified foods fo	or all meals.					
	2 Pagidant #21-	record was reviewed on					
	03/08/11 at 2 p.n						
	~	ed, but were not limited					
	to, Alzheimer's I	Disease and hypertension.					
	The resident's Ph	ysician's Recapitulation					
	Orders, dated 03	/11, indicated an order for					
	fortified foods fo						
	3.1-21(b)						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPLETED	
		155166	B. WING			03/15/2011	
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			606 WA	ALL ST		
		EHABILITATION CENTER	_		RAISO, IN46383		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)		TAG		DATE	
F0371		ation and interview, the	F03	71	F371 SANITARY CONDITIONS The facility must-	04/15/2011	
SS=F	_	distribute and serve food			(1) Procure food from sources		
	under sanitary conditions, related to open				approved or considered satisfacto	ry	
	and undated food, a dirty plate, dirty				by Federal, State or local authorit	-	
	shelves, a pencil	in the utensil drawer, and			and		
	a dirty garbage can lid, for 1 of 1 Kitchen,				(2) Store, prepare, distribute an	•	
		s, toaster, and outdated			serve food under sanitary condition	ons	
	supplements for 1 of 2 Nutritional				This tag is being disputed.		
		d West Unit), 1 of 1			This tag is being disputed.		
	· ·	and 1 of 2 Medication			What corrective action(s) will be	e	
	Rooms (East Uni				accomplished for those residents		
	`	t 120 residents who			found to have been affected by t	he	
	•	prepared in the kitchen,			deficient practice		
	•	d West pantries, the East			The Glucerna 1.2 was		
		•			disposed of 3/9/11. There were n	0	
		or from the activity			residents on this supplement at th		
	room out of a tot	al population of 146.			time of survey.		
					The Activity Room freeze	r	
	Findings include:	:			was cleaned 3/9/11.		
					• The toaster was replaced		
	1. Kitchen				3/9/11.		
					• The East Unit refrigerator cleaned 3/9/11.	was	
	During the initial	l tour on 03/07/11 at 9:45			· The Cottage oven was		
	a.m. to 10:15 a.m	n., with the Registered			cleaned.		
	Dietician Manage	er and the Dietary			The broccoli was thrown		
	_	er, the following was			away on 3/9/11.		
	observed:	<i>y</i>			· The plate was re-washed of	on	
					3/9/11.		
	A In the walk in	n freezer, there was a bag			The shelves were cleaned 3/9/11.	on	
		li opened without an open			The pencil was removed		
		e of the observation, the			from the		
					· drawer and the utensils		
	=	Manager threw the			were cleaned on 3/9/11.		
	broccoli away.				The garbage can lid was	s	
					cleaned on 3/9/11.		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155166		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/15/2011				
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 606 WALL ST VALPARAISO, IN46383					
	SUMMARY S (EACH DEFICIEN REGULATORY OR B. On a shelf wi use plates, there dried food partic Manager took the the time of the of C. A shelf with a plates was dirty. D. A shelf with a hotel pans had di E. There was a plate of the observation Dietician Manage not be in there." F. The garbage of handwashing sin interview at the terms.	EHABILITATION CENTER TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) th stored and ready to were 1 of 4 plates with les. The Dietary Services e plate to be rewashed, at bservation. Stored and ready to use art and food particles. Dencil in the utensil an interview at the time n, the Registered er indicated "That should can lid by the k was dirty. During an time of the observation, ices Manager, indicated "I	606 W	ALL ST	r ntial e and be e he libe itation signee iced hs by 11. facility esult nd/or facility esult nd/or liced into hges t the ecur l clean each	(X5) COMPLETION DATE		
				The Dietary Consultant/designee will complete a weekly sanitation check x 4, then monthly thereafter, and as needed,				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155166			A. BUILD	DING	NSTRUCTION	(X3) DATE SURVEY COMPLETED 03/15/2011	
		199100	B. WING	_	DDDEGG CHTV CTUTE CTD CODE	03/13/2	UII
NAME OF F	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE		
		EHABILITATION CENTER		VALPAF	RAISO, IN46383		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL I SC IDENTIFYING INFORMATION)		REFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	ensure compliance with kitche sanitation. The Dietary Manager is responsible for compliance wit kitchen sanitation. The Housekeeping/Launc Supervisor will complete a sanitation check on the Nutritic Pantry three times weekly for weeks then weekly thereafter.	n h dry onal	DATE

STATEMENT OF DEFICIENCIES (X1) PROVID		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SUR	RVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPLETE	ED
		155166	B. WIN			03/15/2011	1
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	S.		606 WA			
VALPARA	AISO CARE AND R	EHABILITATION CENTER	VALPARAISO, IN46383				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	TE C	OMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
F0371	2. During an obs	servation on 03/08/11 at	F03	71	F371 SANITARY CONDITIONS	0	4/15/2011
SS=F	11:05 of the East	Unit Medication Room			The facility must- (1) Procure food from sources		
	with the East Un	it Manager, there were 17			approved or considered satisfactor	rv.	
		1.2 calorie (dietary			by Federal, State or local authorit	- 1	
		n an expiration date of			and	,	
	02/01/11.	run expiration date of			(2) Store, prepare, distribute ar	nd	
	02/01/11.				serve food under sanitary condition	ons	
	_	view at the time of the East Unit Manager			This tag is being disputed.		
		rses were supposed to			What corrective action(s) will be	e	
		ation room for expired			accomplished for those resident		
		ation room for expired			found to have been affected by t		
	items.				deficient practice		
	_	vironmental tour on a.m. through 10:20 a.m.,			• The Glucerna 1.2 was disposed of 3/9/11. There were n	.0	
		·			residents on this supplement at th		
		nance Supervisor and the			time of survey.		
		upervisor, the following			The Activity Room freeze	r	
	was observed:				was cleaned 3/9/11.		
					• The toaster was replaced		
	· ·	Room freezer had a dark			3/9/11. The East Unit refrigerator		
	_	on the inside door and			cleaned 3/9/11.	was	
	there were crumb	os and dirt on the bottom			· The Cottage oven was		
	shelf.				cleaned.		
					· The broccoli was thrown		
	During an interv	iew at the time of the			away on 3/9/11.		
	observation, the				• The plate was re-washed o	on	
		ezer was suppose to be			3/9/11. The shelves were cleaned		
	cleaned on Mono				3/9/11.	OII	
	2	<i>y</i> -			The pencil was removed		
	B) There was an ac	cumulation of crumbs in the			from the		
	bottom of the toaster located in the West Unit				· drawer and the utensils		
	Nutritional Pantry.				were cleaned on 3/9/11.		
					The garbage can lid wa	s	
	During an interview	at the time of the observation,			cleaned on 3/9/11.		
						ı	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA						(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING		COMPL	
		155166	B. WIN			03/15/2	011
	PROVIDER OR SUPPLIER		-	606 WA		<u> </u>	
VALPAR	AISO CARE AND R	EHABILITATION CENTER		VALPA	RAISO, IN46383		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TΕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION) ger indicated she did not know		TAG	DEFICIENCY)		DATE
	who used the toaste C) The refrigerator Room had a red liqu	_			How will you identify other residents having the potentia to be affected by the same deficient practice a what corrective action will be taken	ınd	
		debris on the bottom of the hall.			All residents have the potential to be effected by the alleged deficient practice. Dietary personnel will be re-educated on kitchen sanitari by the Dietary Manager/design by 4/15/11. All staff will be inservice on proper sanitary conditions in the SDC/designee by 4/15/11. Noncompliance with fact policy and procedure may resign employee re-education and disciplinary action up to and including termination. What measures will be put into place or what systemic change you will make to ensure that the deficient practice does not recombine the place of the process of the combine of the process of the place of the process of the place of the	tion nee d by sility ult for es ne ur ean ch	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
		155166	B. WING		03/15/2011	
NAME OF F	PROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP CODE	!	
				ALL ST		
VALPAR	AISO CARE AND R	EHABILITATION CENTER	VALPA	RAISO, IN46383		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	·	CY MUST BE PERCEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPR		TE COMPLETION	
IAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	IAG	<u> </u>		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	ensure compliance with kitcher sanitation. The Dietary Manager is responsible for compliance wire kitchen sanitation. The Housekeeping/Laun Supervisor will complete a sanitation check on the Nutriti Pantry three times weekly for weeks then weekly thereafter.	th dry onal 4	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPLE	
		155166	B. WIN			03/15/20)11
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
\/A D	AICO CADE AND DI			606 WA			
		EHABILITATION CENTER			RAISO, IN46383		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)			CROSS-REFERENCED TO THE APPROPRIAT	TE	COMPLETION DATE
F0425		ation, interview, and	F04		<u> </u>		04/15/2011
		e facility failed to ensure	1104	23	F425		04/13/2011
SS=F		ons were discarded and a			PHARMACY		
	1 1				FIIAINIACI		
	multiple dose vial of medication was dated when opened for 2 residents in a				SVC-		
	sample of 24 (residents #105 and #147)				ACCURATE		
		n a supplemental sample				_	
	,	#104, #109, #118, #124,			PROCEDURES	S,	
		1, #152, and #153). The			RPH		
	1 *	ensure a multiple dose as discarded within 28			The facility must provide routing	ne l	
					and emergency drugs and		
	' ' '	first opened in 2 of 2 ns (East Unit and West			biological to its residents, or		
		he potential to affect 1 of			obtain them under an agreemed described in 483.75(h) of this	ent	
	1	received insulin (resident			part. The facility may permit		
		of 24, and failed to ensure			unlicensed personnel to		
	multiple dose via				administer drugs if State law		
	· •	ring) were dated when			permits, but only under the general supervision of a licens	sed	
	l `	ad the potential to affect			nurse. A facility must provide		
	_	o reside in the facility.			pharmaceutical services		
					(including procedures that ass the accurate acquiring, receiving)		
	Findings include	·			dispensing, and administering		
	_				all drugs and biologicals) to m		
	1) During an obs	servation of the East Unit			the needs of each resident.		
	Medication Roor	n with the East Unit			facility must employ or obtain services of a licensed pharma		
	Manager on 03/0	8/11 at 11:05 a.m., there			who provides consultation on		
	were 4 opened, p	artially filled, undated			aspects of the provision of		
	vials of tuberculi	n stored in the			pharmacy services in the facili This tag is being disputed. W		
	refrigerator.				corrective action(s) will be	riiat	
					accomplished for those reside		
		iew at the time of the			found to have been affected b	у	
	observation, the East Unit Manager				the deficient practice There is no corrective		
	indicated she wo	uld discard the undated			action for residents since the		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPL	ETED
		155166	B. WIN			03/15/2011	
		<u>I</u>	1		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF 1	PROVIDER OR SUPPLIEF	₹		606 WA	ALL ST		
		EHABILITATION CENTER		<u>.</u>	RAISO, IN46383	_	
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG			DATE
	vials of tubercul	ın.			alleged deficiency was in the		
	2) During an ob Unit, South Hall #9, there was an insulin labeled w The vial indicate on 01/20/11. During an interv observation, RN expired 30 days opened. Resident #F's rec 03/08/11 at 10:3 diagnoses includ diabetes mellitus. The resident's Pf Orders, dated 03 had an order, ori for Novolog insustiding scale (insults) three times 3) During an observed in the resident in the resident Root 03/08/11 at 1 p.m. observed in the resident in the re	servation of the West medication cart, with RN open vial of Novolog with resident #F's name. ed the insulin was opened iew at the time of the #9 indicated the vial after the vial had been cord was reviewed on 0 a.m. The resident's led, but was limited to, 3. hysician's Recapitulation /11, indicated the resident ginally dated 10/19/10, ulin, to be given on a sulin given by blood sugar			How will you identify other residents having the potential be affected by the same defici practice and what corrective action will be taken - All residents have the potential to be effected by the alleged deficient practice. - Q.M.A.'s and nurses will educated to ensure medication are dated when opened and discarded when expired and/or returned to the pharmacy upon non-use by the SDC/designee 4/15/11. What measures will be put into place or what systemic change you will make to ensure that the deficient practice does not recompliately and the deficient and discarded prior to medication administration. - The Unit Managers/designee will check medication carts for proper date and discontinued/expired medications daily (Monday – Friday). How the corrective action(s) who is monitored to ensure the deficient	ent I be ns r n eby es ne ur I /. k	
	(stomach medica	ation) suspension with an					

PRINTED: 04/15/2011 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155166		A. BUILDI	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY ETED 011
		100100	B. WING		DDDDGG GENV GWATT TV CORE	03/15/2	011
NAME OF I	PROVIDER OR SUPPLIER			street al 806 WAI	DDRESS, CITY, STATE, ZIP CODE		
		EHABILITATION CENTER		VALPAR	RAISO, IN46383		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	, i	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		EFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
	expiration date o #105.	f 03/05/11 for resident					
	#105. Resident #105's r 03/08/11 at 1:05 diagnoses include to, cerebellar infa failure. The resident's Ph Orders, dated 03/ lansoprazole orig be given daily an days. B) There was a b (stomach medical expiration date of #147. At the time West Unit Manag was deceased. Resident #147's of reviewed on 03/0 resident's diagnor not limited to, kid metastasis to the	record was reviewed on p.m. The resident's ed, but were not limited arction and respiratory rysician's Recapitulation 711, indicated an order for ginally dated 08/17/10, to ad to discard after 14 rottle of omeprazole tion) liquid with an f 02/06/11 for resident e of the observation, the ger indicated the resident elosed record was 09/11 at 11:10 a.m. The ses included, but were dney cancer with lung and hypertension.					
	Orders, dated 03/	ysician's Recapitulation /11, indicated an order for y, originally ordered on					

PRINTED: 04/15/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155166		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COMP	(X3) DATE SURVEY COMPLETED 03/15/2011	
	PROVIDER OR SUPPLIEF	EHABILITATION CENTER	606 WA	ADDRESS, CITY, STATE, ZIP CODE ALL ST RAISO, IN46383	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE
		es, dated 02/07/11 at 9:50 he resident had passed				
	C) There was a liquid for resider expiration date of					
	Resident #143's record was reviewed on 03/08/11 at 1:12 p.m. The resident's diagnoses included, but were not limited to convulsions and cerebral palsy.					
	The resident's Physician's Recapitulation Orders, dated 03/11, indicated an order for omeprazole two times daily, originally dated on 07/26/11.					
	· ·	n opened, undated vial of for resident #118.				
	Resident #118's record was reviewed on 03/08/11 at 1:10 p.m. The resident's diagnosis included, but was not limited to, diabetes mellitus.					
	Orders, dated 03	nysician's Recapitulation /11, indicated an order for daily per sliding scale, on 07/12/08.				
	· ·	wo bottles of folic acid dates of 02/09/11 and				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

HNBL11 Facility ID:

000083

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE : COMPL	ETED
		155166	B. WIN	G		03/15/2	011
NAME OF I	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE ALL ST		
		EHABILITATION CENTER		VALPAF	RAISO, IN46383		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	DATE
-	02/16/11 for resid			-			
	03/08/11 at 1:15 diagnoses include	record was reviewed on p.m. The resident's ed, but were not limited and congestive heart					
	The Physician's Recapitulation Orders, dated 02/11, indicated an order for Folic Acid daily, originally ordered on 10/22/10.						
	F) There was a bottle of cephalexin (antibiotic) with an expiration date of 03/02/11 for resident #139.						
	03/08/11 at 1:15 diagnoses include	cord was reviewed on p.m. The resident's ed, but was not limited way clearance related to					
	1 *	der, dated 02/16/11, or for cephalexin every 12 or for cellulitis.					
	(stomach medica	bottle of famotidine tion) for resident #151 n date of 02/29/11.					
		cord was reviewed on p.m. The resident's					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155166		(X2) MULTIPLE CONSTRUCTION A. BUILDING D. WING			(X3) DATE SURVEY COMPLETED 03/15/2011	
NAME OF PROVIDER OR SUPPLIER VALPARAISO CARE AND REHABILITATION CENTER			606 W	ADDRESS, CITY, STATE, ZIP CO ALL ST ARAISO, IN46383		
	AISO CARE AND RI SUMMARY S (EACH DEFICIEN REGULATORY OR diagnoses includ to, coronary arter The resident's Ph Orders, dated 03/ famotidine every dated 09/11/10. H) There was a l (muscle relaxer) expiration date o The resident's rec 03/08/11 at 1:20 diagnosis include quadriplegia. The resident's Ph Orders, dated 03/ Baclofen every s 12/31/10. I) There were fo Gentamycin (ant dates of 03/02/11 for resident #152 The resident's rec 03/08/11 at 1:22	EHABILITATION CENTER TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) ed, but were not limited ry disease and stroke. Aysician's Recapitulation /11, indicated an order for /12 hours, originally bottle of Baclofen for resident #124 with an f 03/02/11. cord was reviewed on p.m. The resident's ed, but was not limited to, aysician's Recapitulation /11, indicated an order for ix hours, originally dated ur IV bags of ibiotic) with expiration , 03/04/11, and 03/07/11 cord was reviewed on p.m. The resident's	STREET 606 W	ALL ST	DDE RECTION IOULD BE	(X5) COMPLETION DATE
		ed, but were not limited ilure and chronic kidney				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155166		(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION	(X3) DATE COMP 03/15/2	LETED	
NAME OF PROVIDER OR SUPPLIER VALPARAISO CARE AND REHABILITATION CENTER			STREET A	ADDRESS, CITY, STATE, ZIP COD ALL ST RAISO, IN46383	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	1 -	der, dated 02/27/11 er to discontinue the IV				
	l '	vo IV bags of amikacin expiration dates of dent #153.				
	03/08/11 at 1:25 diagnoses includ	cord was reviewed on p.m. The resident's ed, but were not limited and respiratory failure.				
	1 *	der, dated 02/10/11, er to discontinue the				
		an IV bag of Vancomycin an expiration date of dent #104.				
	03/08/11 at 1:22 diagnoses includ	cord was reviewed on p.m. The resident's ed, but were not limited itus and ischemic heart				
	I -	der, dated 12/2/10, er for Vancomycin every days.				
	L) There was one of tuberculin.	e opened and undated vial				

NAME OF PROVIDER OR SUPPLIER VALPARAISO CARE AND REHABILITATION CENTER (X4) ID PREFIX TAG During an interview at the time of the observation, the West Unit Manager indicated the nurses were supposed to check medications. An undated facility policy, titled, "Storage and Maintenance of Medications", received from RN #2 as current on 03/08/11 at 2:55 p.m., indicated, "Outdated refrigerator items must be removed from the refrigerator" Information obtained from the US Food and Drug Administration Web site on	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155166			(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION	(X3) DATE COME 03/15/	LETED	
PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) During an interview at the time of the observation, the West Unit Manager indicated the nurses were supposed to check medication rooms for expired medications. An undated facility policy, titled, "Storage and Maintenance of Medications", received from RN #2 as current on 03/08/11 at 2:55 p.m., indicated, "Outdated refrigerator items must be removed from the refrigerator" Information obtained from the US Food				STREET ADDRESS, CITY, STATE, ZIP CODE 606 WALL ST				
observation, the West Unit Manager indicated the nurses were supposed to check medication rooms for expired medications. An undated facility policy, titled, "Storage and Maintenance of Medications", received from RN #2 as current on 03/08/11 at 2:55 p.m., indicated, "Outdated refrigerator items must be removed from the refrigerator" Information obtained from the US Food	PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP	ILD BE	COMPLETION	
03/11/11 at 4:45 p.m., indicated Novolog insulin vials could be stored up to 28 days after they were opened. Information obtained from web site, "www.care.diabetesjournals.org", on 03/11/11 at 4:50 p.m., indicated the American Diabetes Association indicated, "opened vials, whether or not refrigerated, must be used within 28 days. They must be discarded if not used within 28 days" 3.1-25(o)		observation, the indicated the nurcheck medications. An undated faciliand Maintenance received from RI 03/08/11 at 2:55 "Outdated refriremoved from the Information obtain Drug Admin 03/11/11 at 4:45 insulin vials coulafter they were of Information obtain www.care.diabet 03/11/11 at 4:50 American Diabet "opened vials, refrigerated, must be dis 28 days"	West Unit Manager reses were supposed to in rooms for expired rooms for expired reses were supposed to in rooms for expired rooms. The state of the state					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		155166	B. WING			03/15/2011	
NAME OF D	DOWNER OF CHIRDHEE		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			606 WA	ALL ST		
		EHABILITATION CENTER			RAISO, IN46383		
(X4) ID		TATEMENT OF DEFICIENCIES	PREFIX (EACH CORRECTIVE ACTION SHOUNDED TO THE APP		PROVIDER'S PLAN OF CORRECTION	I	(5)
PREFIX	*	CY MUST BE PERCEDED BY FULL			CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ATE COMPLETION DATE	
TAG		LSC IDENTIFYING INFORMATION)	F0.4	TAG	F441 INFECTION CONTROL,		
F0441		ation, record review, and	F04	41	PREVENT SPREAD, LINENS	04/15	/2011
SS=E		cility failed to pass ice			The facility must establish and		
		ges to residents in a			maintain an Infection Control		
	manner to preven	nt the spread of infection			Program designed to provide a sa	e,	
	in 1 of 4 dining r	ooms, which had the			sanitary and comfortable		
	potential to affect	t 44 residents who			environment and to help prevent	he	
	received their me	eals in the main dining			development and transmission of disease and infection.		
	room and while p	passing fresh ice water on			uiscase and infection.		
	_	ont hall, which had the					
	potential to affect 16 residents who reside on the front hall of the East Unit. Findings include:				What corrective action(s) will be		
					accomplished for those residents		
					found to have been affected by t	he	
					deficient practice		
	rindings include.	•			T1		
	1 During the lunch	meal on 3/7/11 at 12:28 p.m.,			There is no corrective action for residents since the alleged	on	
	-	served sitting on top of the ice			deficiency was in the past		
	-	ontainer. Activity Assistant #7			deficiency was in the past		
	was observed to pick	k up the ice scoop out of the			How will you identify other		
		asses with ice. The activity			residents having the potential to	be	
		ice scoop back on top of the			affected by the same deficient		
		The activity assistant			practice and what corrective		
	* *	out beverages as the residents			action will be taken		
	come into the dining	3 100III.			· All residents have the		
	On 3/7/11 at 12:30 n	o.m., Activity assistant #7 was			potential to be effected by the alle	ged	
		f the top of the cart with a wet			deficient practice.	<i>-</i>	
	-	ctivity Assistant then held the			· All staff will be educated a	s to	
		vel over the ice container as			proper procedure for passing ice		
	she talked with Activity Assistant #8. Activity				water by the SDC/designee by		
		8 then began filling glasses			4/15/11.		
		urns with the ice scoop and ack on top of the ice in the			· Ice scoop holders have been added to the hydration carts.	n	
		vity assistants continued to			A container with a lid will	ne	
		e residents in the main dining			used when passing ice water i	· ·	
	room.				the dining room. An ice		
					scoop holder has been		
	During an interview	on 3/7/11 at 12:35 p.m., the			added to the cart.		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIF AND PLAN OF CORRECTION IDENTIFICATION NUMB 155166	BER:	MULTIPLE CON ILDING NG	ISTRUCTION	(X3) DATE SURVEY COMPLETED 03/15/2011			
NAME OF PROVIDER OR SUPPLIER VALPARAISO CARE AND REHABILITATION CE	NTER	STREET ADDRESS, CITY, STATE, ZIP CODE 606 WALL ST VALPARAISO, IN46383					
(X4) ID SUMMARY STATEMENT OF DEFICIEN PREFIX (EACH DEFICIENCY MUST BE PERCEDED TAG REGULATORY OR LSC IDENTIFYING INFO	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE			
DoN (Director of Nursing) indicated "No, get the ice scoop in a bag now. At 12:36 Activity Assistant #7 indicated the "ice sc in the ice when it came from the kitchen."	ladies p.m., oop was		What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur The SDC/designee will observe ice water passing at le 3 times weekly for 4 weeks, the once weekly there after. How the corrective action(s) will be monitored to ensure the deficient practice will not recise, what quality assurance program will be put into place. Observations will be documented on the "Passing le Water" skills validation tool weekly x 4, then monthly thereafter by the DNS/designe. Data will be submitted to the CQI Committee for review and follow up. Noncompliance with fact procedures may result in disciplinary action.	east en he eur, e ce			

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		155166	B. WIN		03/15/2011		
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
\/ALDAD		EHABILITATION CENTER		606 WA	ALL ST RAISO, IN46383		
					TAISO, IN40303		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE	
F0441		servation on 03/08/11 at	F04		F441 INFECTION CONTROL,	04/15/2011	
	•	10 was passing ice water			PREVENT SPREAD, LINENS	0 1/13/2011	
SS=E		on the front hallway on			The facility must establish and		
		PN #10 was observed to			maintain an Infection Control Program designed to provide a sa	fa	
		her to the hallway from a			sanitary and comfortable environment and to help prevent the		
	• •	open up the ice chest, and					
	· ·	p, which was being			development and transmission of		
		chest with the ice, and			disease and infection.		
		resident's water pitcher.					
	*	*			What corrective action(s) will be	<u>, </u>	
	LPN #10, then left the ice scoop in the ice chest and took the resident's pitcher back				accomplished for those residents		
		•			found to have been affected by t	•	
		PN #10 then went to the			deficient practice		
		om and filled their ice			TTI		
	•	using the scoop, which			There is no corrective action for residents since the alleged	on	
	was stored in the	ice chest.			deficiency was in the past		
	A C 1114 11 .	4-4-1-00/10 474-1					
		dated 02/10, titled,			How will you identify other		
	_	ee Water", and received as			residents having the potential to	be	
		#2, indicated, "Replace			affected by the same deficient practice and what corrective		
	-	ered container, clean			action will be taken		
	-	ag between rooms to					
	prevent contamir	nation"			· All residents have the		
	0.1.10//				potential to be effected by the alle	eged	
	3.1-19(g)(1)				deficient practice. All staff will be educated a	as to	
					proper procedure for passing ice	15 10	
					water by the SDC/designee by		
					4/15/11.		
					Ice scoop holders have been	en	
					added to the hydration carts. A container with a lid will	he	
					used when passing ice water i		
					the dining room. An ice		
					scoop holder has been		
					added to the cart.		

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Event ID:

HNBL11 Facility ID:

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	OF CORRECTION	IDENTIFICATION NUMBER: 155166	A. BUILDING	JNS1 RUCTION	COMPLETED 03/15/2011
	PROVIDER OR SUPPLIER		606 WA	ADDRESS, CITY, STATE, ZIP CODE ALL ST RAISO, IN46383	1.5
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur The SDC/designee will observe ice water passing at 3 times weekly for 4 weeks, tonce weekly there after. How the corrective action(s will be monitored to ensure deficient practice will not rei.e., what quality assurance program will be put into plate. Observations will be documented on the "Passing Water" skills validation tool weekly x 4, then monthly thereafter by the DNS/design. Data will be submitted the CQI Committee for review and follow up. Noncompliance with faprocedures may result in disciplinary action.	nto I least hen) the cur, ce Ice lee. to

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPL	ETED
		155166	B. WING 03/15/20		011		
			P		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			606 WA			
	AISO CARE AND R	EHABILITATION CENTER		1	RAISO, IN46383		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)	•	DATE
F0514		review and interview, the	F05	14	F514 Clinical		04/15/2011
SS=D	_	ensure residents' records					
	were complete an	nd accurate related to			Records		
	physician's order	s and resident status for 2			The facility must maintain clini	ical	
	of 24 residents re	eviewed for medical		records on each resident in			
	records in a samp	ole of 24. (residents #57			accordance with accepted		
	and #150)				professional standards and		
					practices that are complete; accurately documented; readily	lv	
	Findings include				accessible; and systematically	, ,	
					organized.The clinical record		
	1. Resident #57's record was reviewed on 03/07/11 at 2:10 p.m. The residents				must contain sufficient		
					information to identify the		
		-			resident; a record of the reside		
	_	ed, but were not limited			s assessments; the plan of ca and services provided; the res		
	to, hiatal hernia a	and dementia.			of any preadmission screening		
					conducted by the State; and]	
		der, dated 02/11/11,			progress notes. What		
		er for hospice to evaluate			corrective action(s) will be		
	and treat the resi	dent.			accomplished for those		
					residents found to have been	n	
	A Social Service	note, dated 02/11/11,			affected by the deficient practice • There are not		
	indicated, "Mess	age was left for			corrective actions for alleged		
	GuardianReque	ested (name) call NF			deficient practices because th	ey	
	•	to enable res (resident)			happened in the past. How v		
		spice care" This was			you identify other residents		
		ne resident's record about			having the potential to be		
	the hospice care.				affected by the same deficien		
	me nospice care.				practice and what corrective		
	The resident's rea	aard laakad			action will be taken Residents residing in the facili	tv	
					have the potential to be affect	-	
		indicate the resident			by the alleged deficient practic		
	was receiving ho	spice.			· Physicians have been notifie	ed	
					that they must sign all orders i		
	_	iew with Social Service			the facility. No medical record	is	
	#4 on 03/07/11 a	t 2:45 p.m., she indicated			are to be removed from the facility. Social Services will be	_	
					i acility. Social Services will t	Je	

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED		
		155166	B. WING 03/15/2011					
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE			
TWINE OF T	NO VIDER OR BUTTELEN			606 WA				
VALPAR	AISO CARE AND R	EHABILITATION CENTER		VALPARAISO, IN46383				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	TE COMPLETION			
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)	DATE		
		et a response from the			inserviced on timely documentation in the medical			
		an. She indicated the			record by the DNS/designee b	ov		
	Ombudsman had been notified and they were working with a lawyer to get another				ds			
					Coordinator/designee will			
	Guardian appoin	ted for the resident. She			complete the Physician			
	indicated they ha	d been communicating			Services CQI tool three times	l I		
	this information	to the resident's			week for 4 weeks then weekl	у		
	physician. She is	ndicated there had not			ongoing. The DNS is responsible for	or		
	1	documentation in the			compliance by reviewing the			
	resident's chart about the hospice or the Guardian status. 2. Resident #150's record was reviewed				Physician Services CQI tool wh	en		
					completed.			
					How the corrective action(s)	will		
					be monitored to ensure the			
		a.m. The resident's			deficient practice will not recui i.e., what quality assurance	·,		
					program will be put into place			
		ed, but were not limited			Data will be submitted to the 0			
		ute respiratory failure.			Committee for review and follo	ow		
		been transferred and was			up. Noncompliance with facili	ty		
		emergency room on			procedures may result in			
	09/15/10.				re-education and or disciplinar action.	^{-y}		
	_	nysician's orders located						
	in the resident's of	closed record.						
	<u></u>	02/10/11 + 0.15						
		iew on 03/10/11 at 9:15						
		r of Nursing (DoN)						
		vere no physician's orders						
		losed record. She						
	indicated she wo	uld look for the						
	physician's order	S.						
		iew on 03/10/11 at 12:10						
	l * '	dicated they could not						
	find the resident'	s physician's orders. She						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155166			(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION	COM	TE SURVEY IPLETED 5/2011
NAME OF PROVIDER OR SUPPLIER VALPARAISO CARE AND REHABILITATION CENTER			606 WA	ADDRESS, CITY, STATE, ZIP CO ALL ST RAISO, IN46383	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	papers and there	ad found the transfer were a few physician's out could not find the the other orders.				
	daily conference Administrator in	dicated they were looking bhysician's office for the				